SENATOR LINDA BERGLIN, 61
Senator Paul E. Koering, 12
Senator Tony Lourey, 08
Senator John Marty, 54
Senator Julie Rosen, 24

REPRESENTATIVE TOM HUNTLEY, 07A
Representative Jim Abeler, 48B
Representative Steve Gottwalt, 15A
Representative Diane Loeffler, 59A
Representative Paul Thissen, 63A

85TH LEGISLATIVE SESSION

THE LEGISLATIVE COMMISSION ON HEALTH CARE ACCESS

FINAL REPORT

Recommendations Submitted to the Minnesota State Legislature

February 2008

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Introduction and Background

Legislative Charge

This report was prepared by the Legislative Commission on Health Care Access in response to the following charge in Laws of Minnesota 2007, chapter 147, article 12, section 4:

> "The Legislative Commission on Health Care Access shall make recommendations to the legislature on how to achieve the goal of universal health coverage as described in section 62Q.165. The recommendations shall include a timetable in which measurable progress must be achieved toward this goal. The commission shall submit to the legislature, by January 15, 2008, the recommendations and corresponding timetable."

Section 62Q.165, referred to in the charge, specifies that it is the goal of the state to reduce "the number of Minnesotans who do not have health coverage, so that by January 1, 2011, all Minnesota residents have access to affordable health care."

Makeup of the Legislative Commission on Health Care Access

The Legislative Commission on Health Care Access was established in 1992 (62J.17). The membership of the commission consists of five members of the Senate and five members of the House of Representatives. Currently the membership is as follows:

Senator Linda Berglin (*Co-Chair*)
Senator John Marty
Senator Paul Koering
Senator Julie Rosen
Senator Tony Lourey

Representative Tom Huntley (*Co-Chair*)
Representative Jim Abeler
Representative Paul Thissen
Representative Diane Loeffler
Representative Steve Gottwalt

Process

In recognizing that health care reform cannot be accomplished without the cooperation, input, and investment of all the key stakeholders, working groups were formed by the commission to address the following areas: public health, insurance market reform, cost containment, health care for long-term care workers, single-payer health care, and bridging the health care continuum.

Each working group was composed of House and Senate members of both parties, and representatives of health plans, health care providers, labor unions, counties, employers and other organizations, and consumers. The working groups met over several months, resulting in each working group developing a prioritized list of recommendations that was presented to the commission. The commission then reviewed each working group's recommendations and after further discussion and analysis, developed and finally adopted each of the recommendations contained in this report.

The working groups were as follows:

- Cost Containment: Identify Health Care Costs/Savings (co-chairs Senator Tony Lourey and Representative Erin Murphy)
- Cost Containment: Restructure the Health Care System Through the Identified Savings (co-chairs Senator Linda Berglin and Representative Paul Thissen)
- Development of New Cost Containment Strategies (co-chairs Senator Ann Lynch and Representative Jim Abeler)
- Public Health (co-chairs Senator Patricia Torres Ray and Representative Steve Gottwalt)
- Insurance Market Reform (co-chairs Senator Mary Olson and Representative Diane Loeffler)
- Health Care for Long-term Care Workers (co-chairs Senator Paul Koering and Representative Patti Fritz)
- Single-Payer Health Care (co-chairs Senator Sharon Erickson Ropes and Representative Ken Tschumper)
- Bridging the Health Care Continuum (chair Senator Kathy Sheran)

A complete list of working group members is attached as an appendix to this report.

Structure of the Report

The commission recommendations are grouped thematically into the following sections:

- Public Health
- Health Care Homes
- Affordability
- Continuity of Care
- Health Insurance Reform
- Cost Recapturing Mechanisms
- New Cost Containment Initiatives
- Health Care for Long-term Care Workers
- Universal Coverage
- Continuing Health Care Restructuring

Overview of Commission Recommendations

1. Public Health

1.1: Implement and fund the comprehensive health promotion program, developed by the Minnesota Department of Health (MDH), to promote partnerships among local communities, schools, workplaces, and health care providers to address prevention of chronic conditions statewide.

- Aggressive goals for reduction in obesity, tobacco use, alcohol abuse, and drug addiction should be priorities for the state and for employers, schools, communities, and the health care system.
- By 2011, additional goals should be established for reductions in other health conditions, for improvements in environmental factors, and for prevention of other disease that will reduce health care costs.
- Progress in achieving these goals should be publicly reported.
- The Comprehensive Statewide Health Promotion Plan should be updated annually.

1.2: Adopt in statute, statewide curriculum standards for health, nutrition, and physical education and establish these as graduation requirements for Minnesota schools. The standards must include 30 minutes of activity per day, of which 90 minutes per week must be cardio activity. The state must provide funding to the schools to implement these standards.

1.3: Require MDH, in consultation with the Minnesota Department of Education and other state agencies, to use an existing system to monitor childhood obesity using body mass index (BMI) measures and to report to the legislature on the progress of the BMI monitoring system by July 1, 2009.

2. Health Care Homes and Provider Education

2.1: Establish health care homes for all state health care program enrollees, beginning first with enrollees who have, or are at risk of developing, complex or chronic health conditions.

- The Department of Human Services (DHS) and MDH would certify individual clinicians as health care homes by July 1, 2009.
- Health care homes would receive a care coordination fee that would average $50 per person per month.
- Managed care plans would be required to deliver services to state health care program enrollees using a health care home model by July 1, 2009.

2.2: Require state health care program enrollees to select a primary care provider and complete a health assessment, as part of the overall health care home initiative. Provide state health care program enrollees with education and outreach related to primary care and health care homes.

2.3: Make certain payments to managed care plans contingent on the enrollee choosing a health care home and completing a comprehensive health assessment.

- Managed care plans would receive a one-time assessment fee for each enrollee with, or at risk of developing, a complex or chronic health condition who completes a comprehensive health assessment.

- Regular capitation payments for an enrollee would be paid to managed care plans only after the enrollee has chosen a provider as a health care home.

2.4: Expand funding for primary care provider and rural provider training initiatives.

- Expand funding for primary care and rural physician training initiatives.
- Expand funding for primary care Advanced Practice Registered Nurse training initiatives.
- Provide funding to medical and nursing schools, to address faculty shortages.

2.5: Require MDH to study pharmacist integration with primary care.

2.6: Encourage state agencies to submit recommendations on scope of practice and licensure changes necessary to implement the health care home model.

3. Affordability

3.1: Require employers to establish section 125 plans.

3.2: Establish a health insurance exchange.

3.3: Provide premium subsidies or other forms of financial assistance for persons with incomes not exceeding 400 percent of FPG.

3.4: Raise the MinnesotaCare income limit and establish a new sliding premium scale.

- The MinnesotaCare income limit would be raised to 300 percent of FPG for both families and households without children.
- Enrollee premiums would be limited to 6 percent of gross household income.
- The $50,000 annual income limit for parents on MinnesotaCare would be eliminated.
- Persons with employer-based insurance that requires the enrollee to pay more than 6 percent of gross household income on premiums and cost-sharing would be eligible for MinnesotaCare.

3.5: Increase or eliminate the MinnesotaCare inpatient hospital benefit limit.

3.6: Provide health coverage subsidies for employees and dependents with employer-subsidized insurance coverage, to the extent this is necessary to ensure that employee costs for health coverage do not exceed the affordability standard of 6 percent of household income.

4. Continuity of Care

4.1: Eliminate the MinnesotaCare four-month uninsured requirement.

4.2: Provide delayed verification for state health care programs.

4.3: Provide a premium exemption for the first month of MinnesotaCare enrollment.

4.4: Provide a grace month of eligibility for state health care programs.

4.5: Improve automation and coordination for state health care program outreach and enrollment.

4.6: Minimize asset documentation requirements for state health care program eligibility.

4.7: Require DHS and county agencies to provide enrollees with health care program renewal forms in the appropriate foreign language, using an automated process.

4.8: Require more frequent updates of contact information for state health care programs.

5. Health Insurance Reform

5.1: Establish a set of limited statewide health improvement and outcome measurements and reporting goals, and encourage insurers to use them as the standardized basis for pay-for-performance models.

5.2: The legislature should establish uniform expectations and reporting on the community benefits to be provided by nonprofit health plan companies and on resulting reductions in health care costs.

5.3: Review the study currently being done by Mathematica for MDH, to determine the impact of increasing the size of the small employer definition to more than 50 employees for the purpose of employer health insurance purchasing.

5.4: Adopt a modified community rating system in health insurance, pending review of the results of the Mathematica study being done for MDH, allowing rating differentials only for geography, age, and risk behavior (e.g., smoking).

5.5: Review the study Mathematica is conducting for MDH to determine the impact of merging the individual and small-employer markets.

5.6: The Minnesota Comprehensive Health Association (MCHA) should be maintained until other mechanisms are in place to allow persons with significant health challenges to secure affordable coverage in the marketplace. The financing mechanism for MCHA should be reviewed and, if possible, a broader and fairer funding mechanism should be implemented.

6. Cost Recapturing Mechanisms

6.1: Establish a savings recapture assessment to be paid by health plan companies, health carriers, and third-party administrators.

6.2: Increase the health impact fee on tobacco products.

6.3: Replace some or all of the existing loan forgiveness grants currently provided to primary care physicians under the health professional loan forgiveness program with a targeted Medical Assistance rate increase for primary care physicians who agree to practice in a designated geographic area.

6.4: Create a community benefit pool to which hospitals and health plan companies would be required to contribute in order to retain their not-for-profit status.

6.5: Create a budget forecast mechanism that would recognize the savings from health care initiatives and recapture these savings to be used for health care purposes.

6.6: Require the Commissioner of Human Services to aggressively negotiate growth limits and cost controls in managed care contracts with health plans.

6.7: Ensure that the health care access fund is reserved for health care purposes that are not currently the responsibility of the general fund.

7. New Cost Containment Initiatives

7.1A: Require the establishment of an independent board to develop an evidence-based benefit set and design to ensure that the benefits covered are safe, effective, and scientifically based. This recommendation also requires that in developing this benefit set, specific preventive care services, early diagnostic tests, chronic care coordination services, and prescription drugs are identified as cost effective for purposes of establishing cost-sharing requirements that encourage their use.

7.1B: Require the commissioners of Health and Human Services, in collaboration with the Health Advisory Council, the University of Minnesota, and the ICSI, to develop an evaluation process for new procedures, medications, and technologies to ensure that coverage is provided only for those procedures, medications, and technologies that are safe, effective, and scientifically based.

7.2: Develop a patient-directed decision-making process to be used within the state health care programs.

7.3: Develop a midlevel dental practitioner to work within a collaborative agreement with a licensed dentist.

7.4: Explore the feasibility of a Community Paramedic Pilot Project.

8. Health Care for Long-term Care Workers

8.1: Appropriate funds to the Department of Human Services to obtain the specific data needed to determine the cost of a future rate increase to long-term care employers that would be dedicated to the purchase of employee health insurance in the private market.

9. Continuing Health Care Restructuring

9.1: The legislature should take a global view of the health care system when recommending changes, in order to increase funding flexibility between different health care sectors, avoid unintended consequences, assess the total impact of changes, and reduce cost shifting.

9.2: The commission should work to identify gaps and deficiencies in the health care system and make recommendations on how to create a more individual-centered, seamless health care continuum that allows a smooth transition between providers and services and avoids unnecessary fragmentation.

9.3: Savings in the long-term care system that can be achieved by providing early intervention services to prevent chronic illnesses later in life should be taken into consideration when calculating long-term care costs. The Departments of Human Services and Finance shall recommend changes in state budgeting processes so that, when fiscal notes are being prepared, the impact of proposed legislative changes across traditional budget boundaries is assessed and resources are allocated across those boundaries.

9.4: The legislature and the Legislative Commission on Health Care Access shall continue to study the option of the state transitioning to a single-payer style health care delivery system.

9.5: The Department of Health and the Council of Health Boards are encouraged to review existing statutory and regulatory occupational licensure requirements and the scope of practice limitations created by different licensure levels to identify situations in which health care professionals could provide an expanded level of care.

10. Payment Reform

10.1: Implement Payment Reform Levels 1 and 2, as developed by the Transformation Task Force.

11. Universal Coverage

11.1: Enact a contingent requirement for individual responsibility, requiring all Minnesota residents to have health coverage, only if increased affordability, cost containment, and voluntary efforts fail to achieve the goal of universal coverage. The requirement should be triggered if the following phase-in schedule of interim goals is not met:

- 94 percent insured by end of fiscal year 2009
- 96 percent insured by end of fiscal year 2011
- 97 percent insured by end of fiscal year 2012
- 98 percent insured by end of fiscal year 2013 and thereafter

If any one of these goals for fiscal year 2011 or later is not met, as determined by the Commissioner of Health, the individual responsibility requirement would automatically become effective 12 months later.

Chapter 1: Public Health

This section contains recommendations related to public health, including implementing a statewide comprehensive health promotion program, setting statewide curriculum standards for health, nutrition, and physical education, and establishing a statewide system to monitor childhood obesity.

Recommendation 1.1: Implement and fund the comprehensive health promotion program, developed by the Minnesota Department of Health (MDH), to promote partnerships among local communities, schools, workplaces, and health care providers to address prevention of chronic conditions statewide. The health of Minnesotans must be significantly improved and all major organizations in the state should accept responsibility for helping achieve aggressive health improvement goals.

Background

According to the Centers for Disease Control and Prevention (CDC), chronic conditions, such as heart disease, stroke, and cancer, are the leading causes of death nationwide and in Minnesota.[1] Other examples of chronic conditions include arthritis, asthma, cardiovascular disease, diabetes, and obesity. Nationally, chronic conditions account for between 78 and 83 percent of health care spending.[2] The major causes of chronic conditions—tobacco use, physical inactivity, and poor nutrition—are preventable. Even though we know that chronic conditions are prevalent, costly, and preventable, the number of people affected by chronic conditions continues to grow. In order to provide the most positive and effective change in the prevalence of chronic conditions, both the state and local communities must be involved in coordinated prevention strategies.

Past and Current Efforts

Stakeholders agree that the prevalence of chronic conditions is a major contributor to the rising costs of health care in Minnesota. To be effective, a health care reform strategy should include a plan for chronic disease prevention. There are several programs in communities around the state that address particular chronic diseases, but a comprehensive statewide program is necessary to successfully reduce the prevalence of chronic conditions throughout the state.

Currently, MDH has several programs that address particular chronic diseases, including the Sage program, which provides breast and cervical cancer screening, the Minnesota Cancer Surveillance System, and the Minnesota Diabetes Program. MDH has also developed strategic plans to address asthma and heart disease and stroke prevention. Additionally, in the 2007 legislative session, bills were introduced that proposed funding for colorectal cancer screening, prostate cancer screening, and funding for heart disease and stroke prevention. There have been several proposals in the past to address particular chronic conditions, but this effort is a comprehensive statewide approach to chronic disease prevention.

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[1] Centers for Disease Control and Prevention, *Profiling the Leading Causes of Death in the United States*, November 14, 2005. Available at: http://www.cdc.gov/nccdphp/publications/factsheets/ChronicDisease/minnesota.htm.

[2] National Conference of State Legislatures, *Chronic Disease and Health Costs: A Snapshot for State Legislatures*, 2005. Available at: http://www.ncsl.org/programs/pubs/summaries/0166603-sum.htm; and The Council of State Governments, *Using Sound Science to Prevent Chronic Disease: State Policy Implications*, 2006. Available at: http://www.healthystates.csg.org/Public+Health+Issues/Chronic+Diseases.

Details of the Recommendation

The commission recommends that the state implement and fund the comprehensive health promotion program, developed by MDH, to promote partnerships among local communities, schools, workplaces, and health care providers to address prevention of chronic conditions statewide. Under this program, funding will be made available to local initiatives to provide the following:

1. Safe, accessible, and affordable recreation facilities and activities for all
2. Access to healthy fruits and vegetables, whole grains, and low-fat dairy for all communities
3. Adequate access to physical education classes for students in K-12
4. Initiatives to involve parents and caregivers as key players in efforts to promote healthier lifestyles for their children
5. Walkable neighborhoods, accessible bike trails, and community standards that ensure safe options for vehicles, pedestrians, bicyclists, transit, and safe routes to recreational facilities
6. Nutritious meals and snacks in schools, homes, day care centers, and after-school programs
7. Wellness and nutrition education, and the opportunity to engage in outdoor and physical activity
8. Environmental programs that encourage love of nature and appreciation of the natural world
9. Information that can be disseminated to parents, schools, and communities about healthy choices
10. Partnerships with local food markets to provide tips on healthy meal choices and preparing easy and healthy alternatives to fast food
11. Incentives for workplaces to engage their employees in adult physical activity
12. Campaigns to promote access to and utilization of child checkups, preventive efforts, and culturally appropriate early screening for chronic conditions

The commission recognizes the importance of being able to measure outcomes and emphasizes that monitoring body mass index (BMI) data statewide would be one effective method for tracking the progress of this comprehensive health promotion program.

Currently, four Minnesota communities have a "Steps to a HealthierMN" program. MDH, in partnership with these four communities, receives $2.2 million per year for five years (2004-2009) from the CDC to implement these community-based programs. Steps is the primary model for the department's comprehensive health promotion program. Using the CDC's midline cost estimate, it would cost approximately $26.5 million per year to expand the program statewide, which includes a $50,000-base to each community health board plus $3.89 per person.[3] However, in order to achieve desired results, the CDC's suggested funding level is approximately $8.00 per person. The commission recommends that the comprehensive health promotion program be funded at the optimal

[3] Minnesota Department of Health, *Comprehensive Statewide Health Promotion Plan*, October 1, 2007. Available at: http://www.health.state.mn.us/divs/hpcd/chp/chppages/pdfs/cshpp.pdf.

level. Using the CDC's optimal cost estimate, it would cost approximately $41.5 million per year to expand the program statewide. This estimate includes a $50,000-base to each community health board plus $8.00 per person.

It can be difficult to quantify the savings associated with investments in primary prevention. However, there is evidence that increasing healthy behaviors, and, thereby, reducing the prevalence of chronic diseases, will result in reduced costs to the health care system. For example, it is estimated that $5.6 billion in national heart disease costs could be saved if 10 percent of the population began a regular walking program.[4] Additionally, studies show that wellness programs, particularly in the workplace, are highly cost effective. For example, Citibank saved $8.9 million over two years by implementing wellness programs, which cost $1.9 million (a return of $4.70 for every dollar spent).[5]

There are two identified drawbacks to this recommended approach. First, this comprehensive health promotion program, while it addresses the causes of some of the major chronic conditions, does not address prevention of all chronic diseases. Members of the commission note that a truly comprehensive plan should address all chronic diseases. Second, the midline estimated cost may not be sufficient to achieve desired results. The Steps programs that are currently working in four Minnesota communities receive funding at the higher per-person rate (approximately $8 per person). Therefore, funding this program at the higher level is probably necessary in order to reduce the incidence of chronic disease in Minnesota.

The four Minnesota communities that have implemented Steps programs are seeing positive results. The following are examples of these successes:

- School districts in each community have passed district wellness policies
- In two communities, over 620 physical activity kits have been distributed to families of preschool age children
- More than 600 residents in Minneapolis have attended nutrition education classes, and nutrition information has been distributed to community members in North Minneapolis
- During the summer of 2006, farmers markets were provided in low-income areas of Minneapolis and over 1,200 customers were served
- In Rochester, $5 coupons are available to underserved WIC families, which can be redeemed for fruits and vegetables at the downtown farmers market

MDH is monitoring progress in these four communities and will also measure and analyze core performance measures, as data is available.

Goals for a Statewide Health Promotion System

The commission recommends incorporating the goals for a transformed health promotion system that were identified by the Health Care Transformation Task Force. The goals, as identified by the task force, are set out in this section.

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[4] Center for Disease Control and Prevention, *Preventing Chronic Diseases: Investing Wisely in Health, Preventing Obesity and Chronic Diseases through Good Nutrition and Physical Activity* 2003. Available at: http://www.muni.org/iceimages/healthchp/Preventing%20chronic%20disease.pdf.

[5] The Council of State Governments, Healthy States, *Trends Alert-Costs of Chronic Diseases: What are States Facing?* 2006. Available at: http://www.healthystates.csg.org/NR/rdonlyres/DA24108E-B3C7-4B4D-875A-74F957BF4472/0/ChronicTrendsAlert120063050306.pdf.

1. **Aggressive goals for reduction in obesity, tobacco use, alcohol abuse, and drug addiction should be priorities for the state and for employers, schools, communities, and the health care system.**

The percentages of Minnesotans who are overweight or obese should be reduced as follows:

- Prevent increases in the percentage of Minnesotans who are obese or overweight in 2008 and 2009
- Reduce the total percentage of Minnesotans who are obese and overweight by at least 1 percent per year beginning in 2010, so that no more than 15 percent of Minnesotans are obese, and no more than 35 percent are overweight (i.e., at least 50 percent of Minnesotans have a healthy weight) by 2020

The percentage of Minnesotans who use tobacco should be reduced as follows:

- Continue to reduce the percentage of Minnesotans who use tobacco by 0.2 percent in 2008 and 2009
- Reduce the percentage of Minnesotans who smoke by 2 percent per year beginning in 2010, so the percentage of Minnesotans who use tobacco is cut in half by 2013
- Continue to reduce the percentage of Minnesotans who use tobacco after 2013

The percentage of Minnesotans who abuse alcohol and those who are addicted to drugs should be reduced according to the recommendations of MDH.

All Minnesotans should complete a confidential health-risk assessment each year and establish individual goals for health improvement.

The legislature and state agencies should encourage or require employers, schools, communities, and health care organizations to adopt similar, age-specific goals for each of these priority health conditions and diseases.

- The state should be accountable for achieving goals for its employees.
- The Minnesota Department of Education (MDE) should be encouraged to determine the best way to ensure schools are held accountable for making progress on health promotion goals, particularly health goals that are closely related to learning.

2. **By 2011, additional goals should be established for reductions in other health conditions, for improvements in environmental factors, and for prevention of other disease that will reduce health care costs.**

These goals should be based on an analysis by MDH of the following:

- The magnitude of the impact of a health condition, environmental factor, or disease on health care costs and quality of life
- The potential change in the incidence or prevalence of the condition, factor, or disease based on interventions with demonstrated effectiveness
- The strength of the scientific evidence connecting the condition, factor, or disease to costs

In all cases, goals should be ambitious enough to achieve significant reductions in health care costs or reductions in the growth of health care costs. The goals should also be realistic, based on what has been achieved in the past, what has been achieved in other communities, and what analyses indicate is achievable in the future. In addition to aggregate goals, wherever possible, goals should be disaggregated by demographic groups and by sector (employers, schools, etc.) in order to enable better targeting of interventions and measurement of progress.

3. Progress in achieving these goals should be publicly reported.

MDH should report annually to the legislature on progress toward achieving these goals. To the maximum extent possible, progress measures should be disaggregated by community, organization, and demographic group, in order to identify shortfalls and target technical assistance efforts.

Organizations that implement priority intervention programs and achieve significant progress toward priority goals should receive certification and awards and be publicly recognized. Organizations that fail to achieve progress may be publicly reported.

Each intervention program should report to MDH the cost savings, or increases, in each goal area for each intervention including an analysis of who benefited from the savings (e.g., purchasers, health plans, providers, etc.). MDH will report these findings to the legislature and the public.

4. The Comprehensive Statewide Health Promotion Plan should be updated annually.

MDH should work with appropriate organizations to identify known effective interventions for addressing the highest-risk causes of illness and disease, including interventions directed at both individuals and environmental factors.

Employers, schools, communities, and health care organizations should work together to identify barriers to replication of effective interventions. Examples of barriers might include cost, accessibility, or acceptability. These stakeholders should develop strategies for overcoming identified barriers. When research already exists identifying successful interventions, these interventions should be incorporated into the strategies. When research is insufficient to suggest approaches that work, research and demonstration projects should be undertaken. Additionally, when possible, changes should be made to remove legal or regulatory barriers to implementation of effective programs.

MDH should develop baseline outcome standards consistent with the public health goals outlined in this report and should evaluate programs that are implemented. Successful interventions should be rapidly disseminated and implemented by other appropriate organizations with adequate resources to achieve success. Interventions that are found to be unsuccessful should be promptly eliminated.

Implementation and Responsible Organizations

1. Actions by the state legislature:

    - By July 1, 2008, the legislature and the governor should enact legislation implementing the policy initiatives described in public health recommendation 1.
    - The legislature should annually appropriate sufficient funding to implement the Comprehensive Statewide Health Promotion Plan.

2. Actions by the state executive branch:

   - By January 1, 2009, MDH should establish a confidential online health-risk assessment tool that all citizens can use to identify their health risks and establish individual goals for improvement.
   - The State of Minnesota should encourage its employees to complete an annual health-risk assessment, and it should establish annual goals for improvement of employee health consistent with the statewide goals.
   - By June 30, 2009, the Minnesota Departments of Education and Health should recommend ways to ensure that schools are held accountable for making progress on health promotion goals, particularly health goals that are closely related to learning.

3. Actions by stakeholders:

   - Every employer should encourage its employees to complete an annual health-risk assessment, should establish annual goals for improvement of employee health consistent with the statewide goals, and should implement employee health promotion programs that will enable achievement of the goals.
   - Every public school should encourage its students to complete an age-appropriate annual health-risk assessment, should establish annual goals for improvement of student health consistent with statewide goals, and should implement student health promotion programs that will enable achievement of the goals.
   - Every community should encourage its residents to complete an annual health-risk assessment, should establish annual goals for improvement of its residents' health consistent with statewide goals, and should implement community health promotion programs that will enable achievement of the goals.
   - Every health provider should encourage its patients and employees to complete annual risk assessments, should establish annual goals for improvement of patient and employee health consistent with statewide goals, and should implement health promotion programs that will enable achievement of the goals.

Recommendation 1.2: Adopt in statute statewide curriculum standards for health, nutrition, and physical education and establish these as graduation requirements for Minnesota schools. The standards must include 30 minutes of activity per day, of which 90 minutes per week must be cardio activity. The State must provide funding to the schools to implement these standards.

Background

Childhood obesity has become a major health problem. Studies suggest that overweight children are significantly more likely to become overweight or obese adults. Minnesota was recently ranked 28th in the nation for the percent of the population that is obese, with 61 percent classified as either overweight or obese.[6] Although we do not know the proportion of Minnesota children that are overweight or obese, national estimates indicate that the percentage of children (ages 6-12) overweight has more than doubled in the past 20 years.[7] A presentation by the group Switch reported

[6] Trust for America's Health. *F as in Fat: How Obesity Policies are Failing in America 2007*, August 2007.
[7] Centers of Disease Control and Prevention, *Patterns of Childhood Obesity Prevention Legislature in the United States*, Preventing Chronic Disease, July 2007. Available at: http://www.cdc.gov/pcd/issues/2007/jul/06_0082.htm.

to the Public Health Working Group that school-age children are spending an average of 44.5 hours per week engaged in "screen time." As a result, children are increasingly suffering from conditions traditionally associated with adulthood, including high cholesterol, high blood pressure, early coronary heart disease, congestive heart failure, stroke, asthma, type 2 diabetes, depression, and other psychological disorders.

Past and Current Efforts

Currently, locally developed standards apply for health and physical education requirements in schools.[8] Permitting locally developed standards gives school districts more flexibility, but also creates inequity in standards and programs for students across Minnesota. Interested stakeholders agree that children need to learn healthy eating and activity habits and that nutrition and physical education programs in schools would be beneficial. However, obstacles include the fact that hours in a school day are limited and school districts are financially strained. Schools are spending time and money on programs to meet federal education requirements, which carry very real consequences if they fall short.

The state legislature has addressed the issue of statewide health and physical education standards several times since 2004 when the requirement was changed to authorize locally developed standards. Since then, bills have been introduced that specifically state the number of health and physical education hours that would be required, and others that would permit the MDE to set the standard. However, none of these bills have gone to the governor for signature.

Details of the Recommendation

The commission recommends that the legislature adopt in statute statewide curriculum standards for health, nutrition, and physical education and establish these as graduation requirements for Minnesota schools. The standards must include 30 minutes of activity per day, of which, 90 minutes per week must be cardio activity. The state must also provide funding through MDE to the schools in order for the schools to implement these standards.

The commission emphasizes that this recommendation should not constitute an unfunded mandate to local schools. As new curriculum standards and graduation requirements are adopted, the state should provide the necessary funds for implementing those standards. Additionally, school districts should be given some control in determining how to best meet the statewide curriculum standards.

In setting the new standards, the legislature should consider current initiatives to encourage schools to provide healthy food options for students throughout the day. The State should assist schools in implementing the wellness policies that they have already developed and adopted. Beverage vending policies should continue to be consistent with the "Alliance for a Healthier Generation's School Beverage Guidelines." Other vending and á la carte offerings should be consistent with the recommendations of MDH's "Recommendations to Prevent and Reduce Childhood Obesity in Minnesota." Additionally, schools should provide nutrition education classes to teach students to prepare healthy meals.

Once the new standards are defined, the estimated cost to schools for implementation of the standards should be determined.

[8] Minn. Stat. § 120B.021, subd. 1, cl. 5 (2007).

One potential drawback to implementing this recommendation would be the additional pressures it would put on schools in Minnesota, both in terms of time and cost. Without knowing what exactly the new education requirements would be, it is difficult to state how much it will cost schools. However, providing state funding to schools in order to help them implement these new standards will relieve the financial pressure. The members of this commission agree that it is not their intent to support an unfunded mandate for Minnesota schools.

Recommendation 1.3: Require MDH, in consultation with the MDE and other state agencies, to use an existing system to monitor childhood obesity using body mass index (BMI) measures and to report to the legislature on the progress of the BMI monitoring system by July 1, 2009.

Past and Current Efforts

The stakeholders agree that Minnesota lacks a statewide system to measure and track the rates of childhood obesity. National data can be helpful to estimate the prevalence of the problem in Minnesota, but having reliable state-specific data would be more informative. The members of this commission agree that monitoring BMI data is an appropriate measure of overweight and obesity rates, but they acknowledge that there are other ways of measuring overweight and obesity in children that may also be appropriate.

Currently, there are a number of initiatives around the state that are aimed at reducing the rate of overweight and obese children in Minnesota. Examples include the governor's fit schools program, which provides incentives for schools to meet certain health and nutrition criteria, and the SWITCH pilot program that encourages students to be more active, eat more fruits and vegetables, and to reduce screen time. With regard to monitoring rates of childhood obesity, pediatricians and other health care providers record BMI data on the patients that come into their clinics, but there has not been a statewide effort to monitor childhood overweight and obesity rates in Minnesota.

Several states now have BMI monitoring systems to track obesity rates among various populations. For example, Georgia, which tracks BMI data through its obesity surveillance system, reported that from 2003 to 2005 the percentage of obese children in middle school and high school increased (middle school: from 14 percent to 16 percent; high school: from 11 percent to 12 percent).[9] Monitoring BMI data alone will not prevent childhood obesity, but it is an important tool to quantify trends, measure progress, and target specific communities in need of intervention and prevention services.

Details of the Recommendation

The commission recommends that the state require MDH, in consultation with the MDE and other state agencies, use an existing system to monitor childhood obesity using BMI measures. With this monitoring system, MDH will monitor the incidence of overweight and obese children throughout Minnesota to more accurately target intervention and prevention services to communities. MDH will inform health professionals and the public of the prevalence of overweight and obesity in children in Minnesota. Additionally, MDH will be required to report on the progress of the BMI monitoring system and make recommendations to the legislature by July 1, 2009.

[9] Georgia Department of Human Resources, Division of Public Health, Obesity Surveillance, Obesity Data Summary 2005 and Obesity Data Summary 2006. Available at: http://health.state.ga.us/epi/cdiee/obesity.asp.

A statewide BMI monitoring system will provide a baseline measure of childhood obesity rates in Minnesota so that the state can monitor the progress and outcomes of prevention initiatives. The commission emphasizes the importance of having legitimate, measurable results to report as the state works to prevent childhood obesity.

Currently, there are no state-specific data on the rates of overweight and obesity of children in Minnesota. The most accurate numbers we have are derived from national data. This BMI monitoring system would provide an accurate way to measure and track childhood obesity rates in Minnesota. It is important to have a monitoring system in place to measure whether we are making progress as a state, and whether children are benefiting from current obesity prevention initiatives and from those that will be implemented in the future.

MDH has estimated the cost of implementing and maintaining a BMI monitoring system.

This initiative should complement childhood obesity prevention efforts throughout the state because the purpose of a monitoring system is to identify needs and target prevention efforts.

Chapter 2: Health Care Homes and Provider Education

This section contains recommendations related to establishing health care homes for state health care program enrollees. In order for this concept to be successful, the state must ensure that there is an adequate supply of health care providers, especially in rural areas, to provide services through health care homes. In addition, enrollees should complete a health assessment and participate in developing a health improvement plan with their primary health care provider. For purposes of this recommendation, "state health care programs" means the Medical Assistance (MA), MinnesotaCare, and General Assistance Medical Care (GAMC) programs.

Recommendation 2.1: Establish health care homes for all state health care program enrollees, beginning first with enrollees who have, or are at risk of developing, complex or chronic health conditions.

Background

The current health care system does not adequately meet the needs of patients. The current payment structure is episode driven and gives providers little or no incentive to monitor the health status of a patient between visits. This system centers on the "tyranny of the visit," which pressures providers to increase volume and see more patients in less time, and values visits and procedural services over coordination and management of chronic conditions by health care providers. For Minnesotans with chronic or ongoing conditions requiring care and treatment, care delivery can be disjointed and fragmented, making self-management much more difficult. Health care providers often have difficulty integrating evolving clinical research, best practices, and guidelines for quality into their practices.

The health care home model[10] would address fragmentation and lack of coordination in health care delivery by creating and supporting a long-term, stable, and trusting relationship between the patient and his or her health care provider and that provider's team. The health care home would support and guide the patient through a complex health care system and provide, arrange for, or coordinate all needed health care and related services as part of a whole-person, integrated approach across all care settings.

The health care home would support the reliable delivery of preventive care and disease management through care coordination, which has been shown to increase health care quality and reduce health care spending. The health care home model would support the measurement and public reporting of health care quality, outcomes, and costs, and require providers to meet explicit standards for quality, outcomes, and costs, in order to increase the value received for each health care dollar spent.

There are many pilot and demonstration projects that have incorporated the above elements. This recommendation is an attempt to extend what has been learned from these projects, to the broader fee-for-service and managed care systems for state health care program enrollees and, by doing so, encourage and strengthen private sector efforts that are based on health care home models.

Past and Current Efforts

A number of private-sector organizations in Minnesota have implemented or developed health care

[10] Some members of the working group that developed the health care home recommendation prefer use of the terms patient-centered medical home, medical home, or health home.

home, disease management, and integrated whole-person care management efforts. These include the following:

- *HealthPartners diabetes chronic care improvement program.* The program provides evidence-based care for persons with diabetes and has resulted in a reduction in risk factors as well as reductions in amputations, heart attacks, and retinopathy from complications of diabetes. Improved blood sugar, cholesterol, and blood pressure control can result in estimated savings of $500-600 per patient per year.[11]

- *St. Mary's/Duluth Clinic chronic disease management program for treatment of diabetes, hypertension, congestive heart failure, and asthma.* The treatment module for each chronic condition includes a patient registry, a schedule for appropriate tests, timely follow up, patient compliance, education and support for the patient and family, adherence to Institute for Clinical Systems Improvement (ICSI) guidelines, and feedback for providers. The program has just begun an analysis of cost-savings.

- *DIAMOND Initiative for treatment of depression.* The initiative is a collaboration among the ICSI, primary care medical groups, DHS, and six health plans. The initiative will include practice redesign based on best practice model components and a payment model that supports the best practice model components. It is expected that implementation will begin in 2008. The long-term goal of the initiative is to create a sustainable care management program that is applicable to other chronic diseases.

- *Mayo Clinic efforts to increase the use of primary care physicians by employees.* The Mayo program attempts to connect each employee to a personal physician and includes co-payments for specialty but not primary care. The program replaced a plan that provided first-dollar coverage and open access to specialists. The program is estimated to have resulted in a 10-percent per capita reduction in total health care costs (savings of about $570 per person).[12]

- *Park Nicollet CMS demonstration project on care coordination for congestive heart failure.* The project would be an evidence-based approach to care delivery for Medicare patients with congestive heart failure that would include a care management fee for nonreimbursable care management costs for patients (e.g., equipment, patient outreach, registries, oversight, and assessment and interpretation of data). The project is based on a Park Nicollet congestive heart failure program first implemented in September 2005 that has shown a 61-percent reduction in hospital admissions, estimated annual savings to the Centers for Medicare and Medicaid Services (CMS) of $4,680 per patient, and program costs of $125-133 per patient per month.[13]

In addition, the State of Minnesota has recently implemented or authorized a number of efforts related to health care homes and care coordination. These include Department of Human Services (DHS) initiatives related to:

- Pay-for-performance for medical groups and clinics that demonstrate optimum care in serving individuals with chronic diseases enrolled in state health care programs.

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[11] Patrick O' Connor, *International Journal for Quality in Health Care*, 15 (2003):283-285, as cited in Brian Rank, "Chronic Care Improvement: Diabetes," August 8, 2007 presentation to the Cost Containment: Identify Health Care Costs/Savings working group.

[12] George Schoephoerster and Douglas L. Wood, "Patient-Centered Medical Home," August 14, 2007 presentation to the Cost Containment: Identify Health Care Costs/Savings working group.

[13] Park Nicollet Health Services, Billings Clinic, Geisinger, Marshfield Clinic, and Middlesex Health System, "CHF Care Management Results" (slide presentation), October 2007.

- A patient incentive program for state health care program enrollees who meet personal health goals established with the patient's primary care provider to manage a chronic disease or condition, including but not limited to diabetes, high blood pressure, and coronary heart disease. The program is to be implemented July 1, 2009, or upon federal approval, whichever is later.

- Primary care coordination (previously known as provider-directed care coordination) program for clinics serving fee-for-service MA enrollees with complex and chronic medical conditions. Clinics will be required to develop care plans and have a dedicated care coordinator, an adequate number of patients, evaluation mechanisms, and quality improvement processes. The effective date for the authorizing legislation is January 1, 2008.

- Care coordination pilot projects for children and adults with complex health care needs enrolled in MA fee-for-service programs. DHS is authorized to administer up to four pilot projects. Pilot projects must use primary care clinic models that focus on care coordination and family involvement, provide medical homes, and coordinate services across the continuum of care. At least two of the projects must focus on children with autism or children with complex/multiple-diagnoses physical conditions.

- Medical home learning collaboratives administered in conjunction with MDH and the Minnesota chapter of the American Academy of Pediatrics. Under the collaborative, teams composed of a pediatric provider, clinic-based care coordinator, and two parents of children with special health care needs from separate families meet regularly to plan and implement improvements within the context of a medical home model. The collaborative meets regularly to share information, reinforce medical home principles, and plan future improvements. Initial results have shown more effective coordination of care and a significant decrease in the use of expensive services, with the use of preventive services remaining the same or increasing.

- Minnesota Senior Health Options (MSHO) program. Using a care coordination model, MSHO provides a combined Medicare and MA benefit, including integrated prescription drug coverage, as part of a statewide federal demonstration project. Enrollment in MSHO is voluntary.

- Minnesota Disability Health Options (MnDHO) program. MnDHO is a voluntary managed care program for persons with disabilities under age 65 that operates under combined Medicare and MA authority. The program provides all Medicare primary, acute, and long-term care services and also includes all prescription drug coverage under one plan. The program currently operates in the seven-county metropolitan area.

Details of the Health Care Home Recommendation

A. Fee-for-Service

Criteria for Health Care Homes

DHS and MDH would certify individual clinicians participating in state health care programs as health care homes by July 1, 2009, subject to federal approval. The health care home model will be an expansion of the DHS Primary Care Coordination Program (formerly provider-directed care coordination) authorized under Minnesota Statutes, section 256B.0625, subdivision 51.

Providers may enter into collaborative agreements with other providers to develop the components of a health care home. Provider certification as a health care home is voluntary.

Health care homes must meet the following criteria:

1. Each patient has an ongoing, long-term relationship with a primary care provider trained as a personal clinician to provide first contact, continuous, and comprehensive care. Appropriate specialists and other health care professionals who do not practice in a traditional primary care field can serve as personal clinicians, if they provide care according to the health care home model and accept responsibility for outcomes. A health care home must also allow advance practice registered nurses to serve as personal clinicians.

2. Care is provided using an interdisciplinary team of individuals who collectively take responsibility for the ongoing care of patients, and who practice to the full extent of their license.

3. The personal clinician and the team are responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals, as part of a whole-person orientation. This includes care for all stages of life—preventive care, acute care, chronic care, and end-of-life care. Care must be coordinated across all provider types, all care locations, and the greater community. Care coordination must include ongoing planning to prepare for patient transitions across different types of care and provider types. The primary care team must also coordinate with those providing for the social service needs of the individual, if this is necessary to ensure a successful health outcome. A health care home must provide or arrange for access to care 24 hours a day, seven days a week.

4. Health care homes must encourage the patient and/or family to actively participate in decision making and in clinic quality improvement initiatives, as a full member of the primary care team. Health care homes must consider patients and/or families as partners in decision making, and use patient-centered decision-making protocols when available.

5. Care is facilitated by the use of health information technology and through systematic patient follow-up using internal clinic patient registries.

6. Care is provided in a culturally and linguistically appropriate manner.

7. Care is provided based on evidence-based medicine whenever possible, using clinical decision-support tools, within the context of a system of continuous quality improvement.

8. There is enhanced access to care, using methods such as open scheduling, expanded hours, and new communication methods, such as e-mail, phone consultations, and e-consults.

9. Health care home providers are required to meet specified process, outcome, and quality standards as developed by DHS and MDH, in order to be considered a health care home. Health care homes should monitor, measure, and publicly report all necessary data to DHS and MDH.

10. Health care homes must conduct a comprehensive health assessment for each enrollee determined by the initial health assessment (see Recommendation 2.2) to have, or be at

risk of developing, a complex or chronic health condition. Health care homes must develop and implement a comprehensive care plan to manage complex or chronic conditions based upon the comprehensive health assessment and other information. The care plans must meet criteria specified by DHS and MDH.

11. Health care homes must employ care coordinators to manage the care provided to patients with complex or chronic conditions specified by DHS and MDH.

Health Care Home/Care Coordination Fee

Health care homes will receive a per-person, per-month health care home/care coordination fee for costs related to meeting health care home criteria and providing care coordination services. The fee will be paid for each fee-for-service state health care program enrollee who is served by a personal clinician certified as a health care home. The details of the fee are being developed by DHS as part of the Primary Care Coordination Program.

The health care home/care coordination fee will not exceed an average of $50 per person per month. Fees will be determined by DHS and MDH and will vary by thresholds of care complexity. For example, the fee may be $2.50 per person per month for an individual not requiring care coordination and with low health care needs, and may exceed the $50 per person per month average for an individual requiring care coordination for very complex health care needs or several chronic conditions.

Payment of the health care home/care coordination fee is contingent on the health care home meeting the criteria specified in the previous section.

The health care home/care coordination fee is in addition to reimbursement received by a health care home under the MA fee-for-service payment system.

The health care home model should be implemented in a budget-neutral manner. The cost of the health care home/care coordination fee and related administrative costs should be offset by cost-savings resulting from implementation of the model and/or systemwide reductions in health care spending.

Care Coordination

Each health care home must employ care coordinators. Care coordinators may be social workers, nurses, or other clinicians. Care coordinators are responsible for the following:

- Identifying patients with complex or chronic conditions eligible for care coordination
- Assisting primary care providers in disease management education
- Helping patients coordinate their care or access needed services
- Serving as a patient advocate
- Collecting data on process and outcome measures

State Agency Administration

DHS and MDH should jointly establish qualification standards for health care homes consistent with the principles listed on pages 20-21.

DHS and MDH, in consultation with the Care Coordination Advisory Committee, shall identify complex or chronic conditions for which care coordination is to be required and shall develop criteria for comprehensive care plans for those conditions.

DHS and MDH shall jointly ensure the collection from health care home providers of data necessary to monitor implementation of health care homes and care coordination, evaluate quality of care and outcomes, evaluate patient experience, and determine provider savings. The agencies may collect and evaluate this data directly or through contract with an appropriate private sector entity. The agencies shall provide health care homes with practice profiles on utilization, cost, and quality indicators.

DHS and MDH shall establish a care coordination advisory committee (or continue the advisory committee established for the Primary Care Coordination Program) to assist the agencies in administering the health care home/care coordination model, collecting data, and measuring and evaluating health outcomes and cost savings. If newly established, the committee must include representatives of: primary care and specialist physicians, advanced practice registered nurses (APRNs), patients and their families, health plans, ICSI, MN Community Measurement, and other relevant entities.

DHS and MDH shall establish a health care home collaborative to provide an opportunity for health care homes and state agencies to exchange information related to quality improvement and best practices.

DHS and MDH shall report annually to the legislature on the implementation and administration of the health care home/care coordination model in the fee-for-service sector. The report must include information on the number of state health care program enrollees in health care homes and the number receiving care coordination services, the number and geographic distribution of health care home providers, the performance and quality of care of health care homes, costs related to implementation and payment of health care home/care coordination fees, and estimates of savings.

B. Managed Care

Health Care Homes

Managed care plans would be required, as a condition of contract, to adopt by July 1, 2009, a health care home and care coordination model for serving state health care program enrollees. The criteria for health care homes and care coordination would be those developed for the fee-for-service system. However, DHS, in consultation with MDH, would have authority to waive or modify criteria for individual managed care plans if the agencies determined that performance and quality standards would still be met.

DHS and MDH would collect from plans any data necessary to monitor implementation, measure quality, and determine plan savings. Savings from the use of health care homes would be split among the state, providers, and the managed care plan. The state would retain one-half of the

savings, the plan could retain up to one-fourth of the savings, and at least one-fourth of the savings would be passed on to providers in the form of higher rates.

DHS would provide a performance incentive for expenses related to the operation of health care homes and care coordination that would reimburse up-front costs after a one-year lag, rather than the normal two-year lag. DHS and MDH would establish quality and performance standards for health care homes and care coordination, and these standards would be subject to a capitation rate withhold. DHS would not regulate how managed care plans pay providers for health care home services.

Transparency and Accountability

DHS would annually report to the legislature the rates and other financial arrangements established with managed care plans serving state program enrollees, and estimates of savings obtained from implementation by managed care plans of health care homes and care coordination.

Recommendation 2.2: Require state health care program enrollees to select a primary care provider and complete a health assessment as part of the overall health care home initiative. Provide state health care program enrollees with education and outreach related to primary care and health care homes.

Background

A number of health plans and private employers have begun to encourage enrollees to participate in lifestyle improvement programs with the intent of improving the health of their enrollees or employees, thereby reducing health care costs. To determine each enrollee's health care needs the enrollee is asked to complete a health assessment. In order to ensure compliance, the enrollee is offered a benefit incentive. Dr. Marcus Thygeson from HealthPartners offered an example of this approach. Dr. Thygeson presented a lifestyle improvement case study conducted from 2003 to 2006 by a large manufacturing employer. The study provided a benefit incentive to enrollees who completed a health assessment and who then participated in health improvement programs if the need was indicated. The results showed an increased, sustained improvement in the health of the employees, a 17-percent reduction in non-OB hospital days, and an identified 3.3-percent savings in total claims from 2004 through 2006.[14]

The commission recognizes that the state has influence on a large number of patients within the health care system through the publicly funded state health care programs. Several states have looked at incorporating the use of incentives in their Medicaid programs. For example, West Virginia provides enhanced benefits such as weight management, nutritional counseling, and tobacco cessation programs to enrollees who complete a health assessment and develop a health improvement plan with their primary care provider.[15]

Past Efforts

In 2007, the legislature appropriated $500,000 to DHS for fiscal year 2009 for patient incentive programs. The intent was to provide enrollees who meet certain health goals with incentives, such as a child car seat or a gift certificate. The specifics of this program have yet to be determined by DHS.

[14] New Opportunities for Reducing Health Care Costs, Dr. N. Marcus Thyseson, M.D., Presentation to the Cost Containment Restructuring Working Group, October 2, 2007.
[15] West Virginia New Medicaid Program, Mountain Health Choices.

Furthermore, the Department of Employee Relations (DOER) has successfully incorporated health assessments into the state employee group insurance health program. For the past several years, state employees have been asked to complete a health assessment. If an assessment is completed and the enrollee agrees to follow-up contact with a health coach, the enrollee receives reduced co-payments.

Details of Recommendation

DHS would require state health care program enrollees to select a primary care clinic at the time of enrollment. DHS and county social service agencies would provide enrollees with lists of primary care clinics and providers, and enrollees could also obtain assistance in choosing a clinic by calling a toll-free number.

DHS would require state health care program enrollees served by the fee-for-service system to complete an initial health assessment at the time of enrollment in order to identify individuals with, or who are at risk of developing, complex or chronic health conditions. DHS would require managed care plans, as a condition of contract, to require their state health care program enrollees to complete an initial health assessment at the time of enrollment in order to identify individuals with, or who are at risk of developing, complex or chronic health conditions.

DHS or the managed care plan, as applicable, would provide the results of the initial assessment to the enrollee's primary care clinic. DHS would encourage individuals served by the fee-for-service system who have, or are at risk of developing, a complex or chronic condition to select a primary care clinic, at which clinicians have been certified as health care homes.

DHS would provide patient education and outreach to state health care program enrollees and potential applicants related to the importance of choosing a primary care clinic and a health care home. Education and outreach would be targeted to underserved or special populations.

Recommendation 2.3: Make certain payments to managed care plans contingent on the enrollee choosing a health care home and completing a comprehensive health assessment.

Managed care plans would receive a one-time assessment fee after enrollees who have, or are at risk of developing, complex or chronic health conditions complete a comprehensive health assessment. Comprehensive health assessments would need to meet the criteria established for health care homes.

Managed care plans would be paid the regular monthly capitation payment for an enrollee only after the plan documents, in the form and manner specified by DHS, that the enrollee has chosen a provider to serve as a health care home.

Recommendation 2.4: Expand funding for primary care provider and rural provider training initiatives.

The goal of this recommendation is to expand access to primary care services and reduce disparities in access to services. These recommendations would also expand the supply of primary care providers for health care home initiatives.

Background

The availability of primary care providers is expected to decline in the near future, and the number of new students entering primary care is decreasing. In addition, primary care physicians are leaving the field in disproportionate numbers. The American College of Physicians notes that this will result in "further fragmentation of care and lead to poorer quality, more inefficiencies, and higher health care costs."[16]

Patients with a regular generalist physician have lower overall costs than patients without one. Increased ratios of primary care physicians relative to the population are associated with reduced hospitalization rates for six ambulatory care-sensitive conditions. Health care costs have been found to be higher in regions of the United States with higher ratios of specialists to the population.[17]

Within Minnesota, there is a geographic imbalance in access to primary care physician services. The number of primary care physicians per 100,000 people is 129 in metropolitan counties, 98 in micropolitan counties (rural areas with a population center of 10,000 to 50,000), and 75 in rural counties. The 46 most rural counties in Minnesota have 13 percent of the state's population, but just 5-percent of the state's practicing physicians.[18]

Past and Current Efforts

The legislature and state agencies have recognized the need to increase the supply of health care providers in rural and underserved areas, and over the years have authorized and implemented a number of initiatives. These initiatives include:

- Establishment of the Office of Rural Health and Primary Care within MDH;
- Establishment of health care professional loan forgiveness programs administered by MDH;
- Provision of funding to the University of Minnesota to increase the number of medical school graduates who practice primary care by 20 percent over an eight-year period; establish a rural residency training program in family practice; and implement other primary care initiatives;
- Summer intern and health careers programs, administered by MDH; and
- Establishment of the Health Education Industry Partnership, administered by Minnesota State Colleges and Universities (MnSCU), to identify and address critical health care workforce shortages.

Details of Recommendation

1. Expand funding for primary care and rural physician training initiatives at the University of Minnesota and the Mayo Medical School, to allow these institutions to increase the number of graduates of residency programs who practice primary care. This proposal would build on

[16] American College of Physicians, "A System in Need of Change: Restructuring Payment Policies to Support Patient-Centered Care" Position Paper, 2006.
[17] Thomas Bodenheimer et al. "The Primary Care Specialty Income Gap: Why it Matters" 7: *Annals of Internal Medicine* 4, (February 20, 2007): 301-306.
[18] Minnesota Department of Health, Office of Rural Health and Primary Care, "Minnesota's Physicians Facts and Data 2006" and "Workforce Challenges and Opportunities in Rural Minnesota: Who's Going to Staff the Medical Home?" Presentation to the Cost Containment: Identify Health Care Costs/Savings working group, September 18, 2007.

statutory provisions passed in the early 1990s that provided for a 20 percent expansion in primary care graduates at the University of Minnesota Medical School and authorized related initiatives (see Minn. Stat. §§ 137.38 to 137.40).

2. Expand funding for primary care advanced practice registered nurse (APRN) training initiatives to allow schools of nursing in Minnesota to increase the number of graduates of APRN programs.
3. Provide funding to the University of Minnesota, the Mayo Medical School, and Minnesota schools of nursing, to address faculty shortages in primary care medicine and nursing.

Recommendation 2.5: Require MDH to study pharmacist integration with primary care.

MDH would be required to explore methods of better integrating pharmacists into the primary care team and report recommendations to the legislature by January 15, 2009. MDH would study existing models of using pharmacists to conduct medication reviews and medication therapy management and, in conjunction with DOER, evaluate the medication therapy management program being pilot tested for certain state employees.

The DOER medication therapy management pilot project began in July 2007. The pilot project reimburses participating pharmacies for pharmacy management reviews for state employees who are diabetics. Participating employees receive reduced co-pays for services to treat diabetes and related conditions, and other financial incentives. DOER plans to evaluate health status and service utilization on a quarterly basis.

Recommendation 2.6: Encourage state agencies to submit recommendations on scope of practice and licensure changes necessary to implement the health care home model.

MDH and DHS, in consultation with health licensing boards, should submit to the Legislative Commission on Health Care Access recommendations for any scope of practice and licensure changes necessary to more effectively implement the health care home model and to more fully integrate advanced practice registered nurses and other providers into the primary care delivery system.

Chapter 3: Affordability

Health care reform will not be successful unless health care is affordable and accessible for all Minnesotans. This section establishes an affordability standard that specifies the percentage of gross income an individual or family should be expected to use to obtain quality health care coverage. This section also contains recommendations to ensure that health care coverage is affordable for Minnesotans.

The commission established the following general standard of affordability as a guideline for its recommendations:

- A Minnesotan with a gross household income at or below 300 percent of the federal poverty guidelines (FPG) should not be expected to contribute more than 6 percent of gross income for health care coverage.
- A Minnesotan with a gross household income at or below 400 percent of FPG should not be expected to contribute more than 8 percent of gross income for health care coverage.[19]

An individual's or family's contribution is defined to include the cost of premiums, deductibles, and other out-of-pocket costs. The commission determined that in setting an affordability standard, there was no reason to distinguish between Minnesotans insured through MinnesotaCare and Minnesotans insured through the private market.

The commission recognizes that a variety of mechanisms can be used to assist Minnesotans in obtaining affordable health care coverage. Since individuals and families may access health insurance in different ways (e.g., through an employer, on the individual market, or through public programs), a combination of mechanisms must be made available in a flexible manner to achieve the goal of affordable, accessible health care choices for all Minnesotans.

Recommendation 3.1: Require employers to establish Section 125 plans.

Section 125 plans allow employees to purchase health care coverage on a pre-tax basis. For some middle-income families, such plans may save nearly 60 percent compared to paying for premiums with after tax dollars. The commission recommends that employers with three or more employees be required to establish Section 125 plans

The amount of the Section 125 tax benefit should be subtracted from health care expenditures when calculating the amount an individual is paying for health care for purposes of the affordability standard and eligibility for other premium subsidies.

Recommendation 3.2: Establish a health insurance exchange.

Individuals should have the option of purchasing health coverage through a health insurance exchange. The health insurance exchange would certify that the plans offered through the exchange meet specified coverage criteria. This would ensure that the health plans that are purchased with a subsidy (see Recommendation 3.3) provide high quality and comprehensive health care. (The

[19] The recommended sliding fee scale up to 400 percent of poverty is specified in Tables 1 and 2.

Commissioner of Health is required to present recommendations to the legislature on a health insurance exchange by February 1, 2008.)

Recommendation 3.3: Provide premium subsidies or other forms of financial assistance for persons with incomes not exceeding 400 percent of FPG.

Premium subsidies should be provided to Minnesotans with incomes that do not exceed 400 percent of FPG who would otherwise pay more than the amount set forth in the affordability standard. Premium subsidies should be available only for policies meeting standards established by the health insurance exchange. The amount of the subsidy would be the difference between the affordability standard and the cost to an individual of premiums and deductibles for the lowest cost policy meeting the standards.

The mechanisms for meeting the affordability standard may include:

- Allowing employees to use a cash voucher, equivalent to the employer share of premiums, for the purchase of insurance through a health insurance exchange;
- Creating an advanceable, refundable tax credit for Minnesotans with high health care costs; and
- Establishing an uncompensated care pool for Minnesotans with high health care costs.

Recommendation 3.4: Raise the MinnesotaCare income limit and establish a new sliding premium scale.

The MinnesotaCare income limit for both families and children and adults without children should be increased to 300 percent of FPG and a new sliding scale premium schedule should be established that limits enrollee premiums to a maximum of 6 percent of gross household income. As part of this recommendation, the "hard" income limit of $50,000 per year for parents on MinnesotaCare would be eliminated.

The current MinnesotaCare income limits are 275 percent of FPG for families and children and 200 percent of FPG for adults without children.[20] The maximum premium for MinnesotaCare is 9.8 percent of gross household income.[21]

Recommendation 3.5: Increase or eliminate the inpatient hospital annual benefit limit.

The commission recommends increasing or eliminating the MinnesotaCare inpatient hospital annual benefit limit. By increasing or eliminating this benefit limit, the coverage provided under MinnesotaCare would be more comprehensive for these enrollees and would alleviate the possibility of an enrollee incurring health care costs over the recommended affordability standard.

[20] The MinnesotaCare income limit for adult without children was increased from 175 percent of FPG to 200 percent of FPG on January 1, 2008. Under current law, this income limit will increase to 215 percent of FPG on July 1, 2009.

[21] This maximum percentage reflects premium increases of 0.5 or 1.0 percentage points, depending upon income, that took effect October 1, 2003. The 2007 Legislature eliminated these increases, but federal approval for this change was still pending as of January 7, 2008.

Currently, the inpatient benefit limit is set at $10,000 and applies to all adults without children and to parents with household incomes exceeding 175 percent of FPG. Children, pregnant women, and parents with household incomes at or below 175 percent of FPG are not subject to the limit. The inpatient hospital limit of $10,000 was established in 1993 as part of the original MinnesotaCare legislation and at that time applied to all adults. The amount of the benefit limit has never been increased. In 1997, parents with household income under 175 percent of FPG were excluded from the limit.

Recommendation 3.6: Provide health coverage subsidies for employees and dependents with employer-subsidized insurance coverage, to the extent this is necessary to ensure that employee costs for health coverage do not exceed the affordability standard of 6 percent of household income.

The state should provide employees with subsidies for the cost of the employee share of employer-subsidized health coverage, if the cost to the employee for this coverage exceeds the 6-percent affordability standard and other criteria are met. This would maintain and encourage employer-based health coverage, minimize cost-shifting to MinnesotaCare, and support continuity of care.

In order to qualify for a subsidy, an employee and his or her dependents would need to meet all MinnesotaCare eligibility criteria except those related to not having other health coverage and not having access to employer-subsidized coverage. The employer must contribute at least 50 percent of the cost of coverage and subsidies would be provided only for fully insured, standardized policies offered through the health insurance exchange. The subsidy would equal the amount by which employee costs for health coverage (including premiums, deductibles, and other cost-sharing) exceed the 6-percent affordability standard, except that the maximum subsidy must not exceed the subsidy that would be provided under the MinnesotaCare program, were the employee and any dependents eligible for that program.

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Table 1

Recommended Premiums for MinnesotaCare at 300% of FPG

	Household Size	Gross Monthly Income	Average Premium For Range	% of Income
MinnesotaCare	**1**	$0-280	$4	minimum
	1.1%-6.0%	281-467	5	1.1%
		468-701	7	1.2
		702-935	13	1.6
		936-1,169	25	2.4
		1,170-1,403	37	2.9
		1,404-1,638	59	3.9
		1,638-1,872	81	4.6
		1,873-2,106	107	5.4
		2,107-2,340	133	6.0
		2,341-2,553	147	6.0
	2	$0-583	$8	minimum
	1.2%-6.0%	584-902	9	1.2%
		903-1,222	17	1.6
		1,223-1,541	33	2.4
		1,542-1,860	49	2.9
		1,861-2,180	79	3.9
		2,181-2,499	108	4.6
		2,500-2,819	144	5.4
		2,819-3,138	179	6.0
		3,139-3,423	197	6.0
	3	$0-709	$12	minimum
	1.2%-6.0%	710-1,112	11	1.2%
		1,113-1,515	21	1.6
		1,516-1,919	41	2.4
		1,920-2,322	62	2.9
		2,323-2,725	98	3.9
		2,726-3,129	135	4.6
		3,130-3,532	180	5.4
		3,533-3,935	224	6.0
		3,936-4,293	247	6.0
	4	$0-828	$12	minimum
	1.2%-6.0%	829-1,316	13	1.2%
		1,317-1,804	25	1.6
		1,805-2,293	49	2.4
		2,294-2,781	74	2.9
		2,782-3,269	118	3.9
		3,270-3,757	162	4.6
		3,758-4,246	216	5.4
		4,247-4,733	269	6.0
		4,734-5,136	296	6.0

Prepared by David Godfrey, Senate Counsel, Research and Fiscal Analysis

Table 2

Affordability Table for Incomes between 300% and 400% of FPG

Household Size	FPG Range	Gross Monthly Income	Average Monthly Cost For Range	% of Income
1				
	301%-324%	$2,562-$2,757	$173	6.5%
	325-349	2,758-2,970	206	7.2
	350-374	2,971-3,183	240	7.8
	375-400	3,184-3,404	264	8.0
2				
6.5%-8.0%	301%-324%	$3,434-$3,697	$232	6.5%
	325-349	3,698-3,982	276	7.2
	350-374	3,983-4,267	322	7.8
	375-400	4,268-4,564	353	8.0
3				
6.5%-8.0%	301%-324%	$4,307-$4,636	$291	6.5%
	325-349	4,637-4,994	347	7.2
	350-374	4,995-5,352	404	7.8
	375-400	5,353-5,724	443	8.0
4				
6.5%-8.0%	301-324	$5,180-$5,576	$350	6.5%
	325-349	5,577-6,006	417	7.2
	350-374	6,007-6,437	485	7.8
	375-400	6,438-6,884	533	8.0

Prepared by David Godfrey, Senate Counsel, Research and Fiscal Analysis

Chapter 4: Continuity of Care – State Health Care Programs

This section contains recommendations to ensure greater continuity of health care for state health care program enrollees. Providing greater continuity of care would improve the health status of enrollees and reduce complications that can result from interruptions in care necessary to treat complex and chronic conditions.

Recommendation 4.1: Eliminate the four-month uninsured requirement.

The commission recommends eliminating the four-month uninsured period for MinnesotaCare eligibility to allow families and individuals to be eligible for coverage immediately upon losing health insurance. Federal approval is required for this change.

Under current law, an applicant must not have had insurance coverage for the four months prior to application or renewal in order to be eligible for MinnesotaCare. This requirement does not apply to children from households that do not exceed 150 percent of FPG if the child's other coverage: (1) lacks two of the following: basic hospital coverage, medical-surgical coverage, prescription drug coverage, dental coverage, or vision coverage; (2) requires a deductible of $100 or more per person per year; or (3) lacks coverage because the maximum coverage for a particular diagnosis has been met or is excluded. The requirement was put in place as a disincentive against crowd-out (employers dropping coverage because a public alternative is available).

The commission is concerned about continuity of coverage. This goal is not served when individuals who lose employer-sponsored coverage and either cannot afford to continue coverage under COBRA[22] or reach the end of their COBRA benefits, must go four months without health coverage before becoming eligible for MinnesotaCare. Eliminating the four-month waiting period also streamlines the application and eligibility process, improving administrative efficiencies and removing barriers to coverage.

Recommendation 4.2: Provide delayed verification for state health care programs.

The commission recommends allowing delayed verification for, MA, MinnesotaCare, and GAMC. An applicant who initially appears to meet income, asset, and other program eligibility criteria would be automatically eligible for the program, upon application and, for MinnesotaCare, payment of an estimated premium, and would have 60 days to submit required verifications. If required verifications were not submitted within this time period, eligibility for the program would be terminated. Federal approval is required for this change.

Delayed verification is an option under federal law that allows state Medicaid programs to grant immediate eligibility to applicants, while giving the applicant additional time to submit required verifications. Delayed verification for MA was authorized by the legislature in 1999 for applicants: (1) whose gross income was less than 90 percent of the applicable income standard; (2) whose liquid assets were less than 90 percent of the asset limit; (3) who did not reside in a long-term care facility; and (4) who met all other eligibility requirements. Individuals meeting these criteria were determined eligible by the county agency beginning in the month of application. Applicants were

[22] The federal Consolidated Omnibus Budget Reconciliation Act (COBRA), passed in 1985, requires heath plans to allow former employees and their dependents to pay the full premium for continued health coverage, generally for 18 months at 102 percent of the cost of group coverage.

required to provide all required verifications within 30 days' notice of the eligibility determination, or eligibility would be terminated. This delayed verification provision was eliminated during the 2003 legislative session. This proposal would extend this concept in modified form to MinnesotaCare and GAMC, as well as to MA.

Recommendation 4.3: Provide a premium exemption for the first month of MinnesotaCare enrollment.

Under this recommendation a new enrollee would not be charged a premium for the first month of enrollment in MinnesotaCare. A "new enrollee" is defined as an individual who has not been enrolled in MinnesotaCare in the year prior to application. Federal approval is required for this change.

Recommendation 4.4: Provide a grace month of eligibility for state health care programs.

Under this recommendation a one-month grace period of eligibility would be established for state health care programs (MA, MinnesotaCare, and GAMC). An enrollee who fails to submit renewal forms and related documentation in a timely manner at renewal, or fails to pay MinnesotaCare premiums, would remain enrolled for one additional month before becoming ineligible. Federal approval is required for this change.

Under current law, state health care program enrollees who fail to submit renewal forms and related documentation are disenrolled at the end of the current eligibility period, and are provided with ten days' advance notice of disenrollment. MA enrollees who are disenrolled, but then submit their renewal materials in the month following closure, can have coverage reinstated with no gap in eligibility.

MinnesotaCare enrollees who fail to pay premiums by the premium due date (approximately two weeks before the first day of the new month of coverage) receive an overdue premium notice and a notice of cancellation. They then are disenrolled for the new month of coverage if the premium payment is not received by the last business day before the start of the new month of coverage. Enrollees who pay all premiums owed by the 20th day of the month for which coverage was lost can have their MinnesotaCare coverage reinstated to the first day of that month. Persons who are disenrolled for nonpayment may not reenroll in MinnesotaCare for four months, unless the person can show good cause for nonpayment. MinnesotaCare at one time provided a grace month to enrollees for nonpayment of premiums; this grace month was eliminated July 1, 2002.

Recommendation 4.5: Improve automation and coordination for state health care program outreach and enrollment.

The commission recommends that DHS improve automation to enhance outreach and enrollment efforts for health care programs. DHS should improve coordination between state health care programs and social service programs such as WIC, free lunch programs, and food stamps, and use automated systems to identify those who may be eligible for but are not enrolled in a state health care program.

Recommendation 4.6: Reduce asset documentation requirements for Medical Assistance eligibility.

Under current law, DHS is required to verify all countable assets (see Minn. Stat. § 256B.056, subd. 10, para. (c)). The commission recommends that DHS reduce MA asset documentation requirements by requiring verification of liquid assets only if the applicant or enrollee is within 10 percent of the applicable asset limit.[23] Verification of nonliquid assets would not be required.

This change would have the effect of reinstating, in modified form, the asset verification requirement for MA that was in effect prior to September 1, 2005, and making the MA asset verification requirement similar to that for GAMC.

Recommendation 4.7: Require DHS and county agencies to provide enrollees with health care program renewal forms in the appropriate foreign language, using an automated process.

The DHS web site provides access to Minnesota health care program applications and renewal forms in the following foreign languages: Arabic, Hmong, Khmer (Cambodian), Lao, Oromo, Russian, Serbo-Croatian (Bosnian), Somali, Spanish, and Vietnamese. The site also provides contact phone numbers for persons speaking the above languages to call to obtain language assistance. Health care program applications in the above languages are available at county social service agencies.

However, DHS uses a manual, rather than an automated, process to send out health care program renewal forms in a foreign language. Enrollees who require a program renewal form in a foreign language therefore do not always receive a program renewal form in that language. This recommendation would require DHS and county agencies to send out renewal forms in the appropriate foreign language, using an automated process.

Recommendation 4.8: Require more frequent updates of contact information for state health care programs.

The commission recommends that DHS and local agencies be required to update enrollee addresses and related contact information at the time of each enrollee contact. This would provide more up-to-date contact information for program and service outreach and eligibility renewals, and allow more efficient delivery of services through a health care home model.

[23] MA asset limits do not apply to pregnant women and children. The MA asset limit for persons who are aged, blind, or disabled is $3,000 for a household of one and $6,000 for two-person households, with $200 for each additional dependent. The MA asset limit for parents is $10,000 for a household of one and $20,000 for a household of two or more. Prior to September 1, 2005, the MA program verified liquid assets if assets were within $300 of the limit. This proposal, by requiring asset verification if within 10 percent of the applicable limit: (1) retains the $300 threshold for the aged, blind, or disabled for a household of one; (2) provides higher thresholds for larger households of persons who are aged, blind, or disabled; and (3) increases the threshold for parents to $1,000 or $2,000, depending upon household size.

Chapter 5: Health Insurance Reform

This section contains recommendations involving the private insurance market that are consistent with the other sections of this report. The recommendations focus on insurance reforms targeted at cost containment, improved purchasing, risk sharing, and affordable coverage. These recommendations are designed to contribute, along with other sections of this report, to universal, affordable health coverage by 2011.

Recommendation 5.1: Establish a set of limited statewide health improvement and outcome measurements and reporting goals, and encourage insurers to use them as the standardized basis for pay-for-performance models.

Providers have commented on the administrative burden placed upon them in collecting and reporting different data to various insurers for their "pay for performance" systems. Insurers often have minor differences in the data collected for measuring progress on the same goal. Those differences are costly at the provider level. A standardized, limited set of measures would not only reduce costs but also allow the state to monitor the progress of public/private health promotion efforts. An implementation objective would be to have the same definitions, same measures, and same forms for submitting data. These targets should be set in a public process that involves consumers and public health agencies, in addition to providers, purchasers, and insurers. The Commissioner of Health should convene the group, and it should use the expertise of the many existing organizations addressing quality measurement including: Minnesota Community Measurements, ICSI, Stratis Health, Bridges to Excellence, and the Minnesota Hospital Association.

Recommendation 5.2: The legislature should establish uniform expectations and reporting on the community benefits to be provided by nonprofit health plan companies and on resulting reductions in health care costs.

Minnesota law provides special privileges to nonprofit health plan companies, such as health maintenance organizations and nonprofit health service plan corporations. These privileges are granted with the expectation that these companies will benefit the health of the state's residents as a whole and not just the companies' enrollees. See Minnesota Statutes 2007, section 62C.01, subdivision 2 ("…advance public health and the art and science of medical and health care within the state…") and Minnesota Statutes 2007, section 62D.01, subdivision 2 ("Faced with the continuation of mounting costs of health care coupled with its inaccessibility to large segments of the population, the legislature has determined that there is a need to explore alternative methods for the delivery of health care services, with a view toward achieving greater efficiency and economy in providing these services.")

The expectations of community benefits provided and reported on by nonprofit health plan companies should be related to the statutory missions of those entities and not to general philanthropic endeavors. The special role of nonprofit health plan companies in the Minnesota marketplace is based on enhanced value-added, and a clearer delineation of value-added will increase consumer and purchaser confidence in the value of that special role.

In 2007, the legislature enacted a requirement of annual reporting on community benefit and community care provided by nonprofit hospitals (Minn. Stat. 2007, § 144.699, subd. 5). Recommendation 6.4 in this report suggests further refinement of that requirement for nonprofit hospitals. This recommendation would extend that general concept to nonprofit health plan

companies. Under this recommendation, the Commissioner of Health would be required to establish uniform community benefit standards and reporting requirements for nonprofit health plan companies and report to the legislature by January 15, 2010.

Recommendation 5.3: Review the study currently being done by Mathematica for MDH, to determine the impact of increasing the size of the small-employer definition to more than 50 employees for the purpose of employer health insurance purchasing.

The definition of "small employer" (Minn. Stat. 2007, § 62L.02, subd. 26) determines the size of employers that are included in Minnesota's small employer insurance market. Employers in that market cannot be turned down for employee health insurance coverage, and the premium rates in that market are permitted to vary based on health status, age, and other permitted characteristics of the employee group only within limits specified in law. This has provided small employers with more availability and stability in their employee health insurance than would otherwise be the case.

When the small-employer insurance laws were enacted in 1992, the definition of small employer included only employers with up to 29 employees. The legislature expanded the definition in 1994 to 49 employees, and in 1997 to 50 employees.

It is possible that raising the upper limit above 50 would benefit the additional employers that would be brought into the small-employer market. Employers in the range of, for instance, 50 to 100 employees are arguably more similar in their health insurance needs to smaller employers than to larger ones, since self-insurance is not usually a viable option for employers in that size range. Employers already in the small-employer market may benefit from the increased size, stability, and risk-spreading ability of an expanded small-employer market. The protections now provided to small employers may also be appropriate for employers of a larger size that are not large enough to avoid significant risk of having a disproportionate number of high-cost employees or dependents.

Recommendation 5.4: Adopt a modified community rating system in health insurance, pending review of the results of the Mathematica study being done for MDH, allowing rating differentials only for geography, age, and risk behavior (e.g., smoking).

State law regulates the factors that insurers are permitted to use in setting premiums and the extent to which those factors may result in differences in premiums charged for coverage. Those rating factors and the rate bands that limit their use affect the affordability of insurance for any given individual. It may, therefore, be possible for changes in the rating factors and the associated rate bands to change the net affordability of coverage.

Under current law, the regulation of premium rate differentials applies to both the individual and small employer markets. In the individual market, rates are allowed to vary, within limits, for health status, claims experience, occupation, age, and geography. In the small-employer market, rates are allowed to vary, within limits, for health status, claims experience, industry of the employer, duration of coverage, age, and geography. In both cases, health status can include refraining from smoking or other lifestyle factors approved by the commissioner.

The term "community rating" means a rating system that permits no premium variations except for differences in the insurance products. "Modified community rating" can be defined in a variety of ways, but generally means a rating system that excludes health status and claims history, and

includes at least age. This recommendation is therefore correctly called a modified community rating system.

This recommendation would simplify pricing and leave age and geography as the remaining major factors causing differentials in premium rates among individuals and small employers. This change would tend to reduce premiums for individuals and employers with higher-cost health status and claims history and increase premiums for individuals and employers who are now lower-cost on those factors. Health status and claims history can change from year to year, so the elimination of those factors would eliminate variations based on comparatively random factors. One can argue that elimination of such variations can be a valuable purpose of insurance.

In moving to modified community rating, it would be logical to consider adjusting the current rate bands for the rating variables that would still be used under modified community rating. Those remaining rating variables and their current rate bands would be:

- Age (now plus or minus 50 percent of the index rate),
- Geography (now an actuarially valid adjustment approved by the commissioner, based upon the regions used by that insurer and upon the geographic differences in cost to the insurer for those regions); and
- Actuarially valid healthy lifestyle factors such as tobacco use (now part of the overall health status, claims history, etc., rate band of plus or minus 25 percent).

If nothing else, the use of healthy lifestyles as a rating factor on its own would require specification of a rate band for it as a stand-alone factor, which could be simply a percentage determined by the commissioner to be actuarially valid for the particular healthy lifestyle or could be subject to some statutory limit.

It may be wise to phase in the elimination of health status and claims history as rating factors to reduce the risk of short-term disruption in the market.

Recommendation 5.5: Review the study Mathematica is conducting for MDH to determine the impact of merging the individual and small-employer markets.

A complete merger of the individual and small-employer markets would result in an individual being treated the same, whether applying for coverage as an individual or as an employee of a small employer. The individual would be rated for underwriting purposes on the basis of the same criteria and in the same manner in the two situations. The premium charged to the individual in the individual market would be the same as the premium that would be charged to the individual's employer for that individual's coverage if the individual were in the small-employer market. In addition, the ability to reject an applicant or impose preexisting condition limitations would be the same.

Under current Minnesota law, an individual is treated differently depending upon whether the individual is applying for coverage in the individual or small-employer market. The underwriting factors used in determining the permitted variations around the midpoint of premiums charged in the two markets are almost identical. The only underwriting differences are that occupation may be used in the individual market while industry of the employer may be used in the small-employer market and that duration of coverage (length of time since the policy was originally issued) may be used in the small-employer market but not in the individual market. Those are relatively minor factors that

insurers do not always choose to use. Although the permitted variations around the midpoint of the premium range are virtually identical in the two markets, the midpoints, and therefore the top and bottom of the premium ranges, are allowed to differ without limit between the two markets. The relationship between the level of premium rates in the two markets depends upon the extent of actual use of permitted underwriting factors in the two markets, including the ability to reject an applicant in the individual market, since there is no guaranteed issue in the individual market. If an insurer now has very strict underwriting standards in the individual market and therefore rejects applicants who have any hint of a present or future health problem, the premium charged in that market for a given individual may be less than that charged for that same individual in the small-employer market.

Merging the individual and small-employer markets would therefore require:

- Eliminating the current minor differences in premium rating factors,
- Requiring the resulting premium rates to be identical for any given individual in the two markets; and
- Requiring guaranteed issue in the individual market or repealing guaranteed issue in the small employer market.

Minnesota's private insurance market is quite different from other states and merging the two markets might have very different effects here. In particular, Minnesota has managed to maintain a relatively large individual market as compared to some other states. The expected effects of a merger would depend largely on how such a merger is paired with other components of insurance reform.

Merging the two markets and requiring guaranteed issue, while eliminating the Minnesota Comprehensive Health Association (MCHA) with no other changes to the system, could cause premiums to increase for those covered as individuals. Small-employer premiums may decrease on average, and enrollees previously covered by MCHA would also likely experience reduced premiums on average.[24] Without pressures forcing healthy individuals to remain in the market, premiums would ultimately increase even more for those remaining in the merged markets.

Recommendation 5.6: The Minnesota Comprehensive Health Association (MCHA) should be maintained until other mechanisms are in place to allow persons with significant health challenges to secure affordable coverage in the marketplace. The financing mechanism for MCHA should be reviewed and, if possible, a broader and fairer funding mechanism should be implemented.

The MCHA (pronounced "em-cha") is a private sector health insurance pool created under state law to provide coverage for Minnesota residents who do not have access to employer-sponsored health coverage and are rejected for coverage in the private individual market due to a preexisting, usually chronic, health condition. It is a private nonprofit corporation, but its board members are appointed by the Commissioner of Commerce. Current enrollment is 25,000 to 30,000. Enrollees pay premiums that are required by law to be between 101 percent and 125 percent of what a healthy

[24] These are very general estimates that require an actuarial analysis. Minnesota Department of Commerce, *Report of 2005 Loss Ratio Experience in the Individual and Small Employer Health Plan Markets for: Insurance Companies, Nonprofit Health Service Plan Corporations and Health Maintenance Organizations,* June 2006; and Minnesota Department of Health, *Health Economics Program, Section 2: Trends and Variation in Health Insurance Coverage* 7 (July 2007).

person of the same age would be charged in the individual market for equivalent coverage. The exact percentage within that range is determined by the Commissioner of Commerce each year based upon factors specified in law, and is currently 119 percent. Enrollees are offered a variety of enrollee cost-sharing options, including a high deductible health plan that qualifies under federal law for use with a health savings account.

The premiums paid by enrollees overall cover roughly 50 percent of the total cost of their health care. The other 50 percent is paid for through assessments MCHA is required to make on health insurers in proportion to each insurer's share of Minnesota health insurance premiums. The assessments are paid directly to MCHA and used by MCHA to cover its costs and therefore do not require a legislative appropriation. These assessments are currently about 2 percent of health insurance premiums, and insurers pass them on to purchasers of insurance in the form of higher premiums.

The federal Employee Retirement Income Security Act (ERISA) preempts any state law that affects the self-insured health plans often sponsored by large employers and multiple employer unions. This prevents MCHA from assessing those self-insured plans, which are now the source of coverage for more than 50 percent of Minnesota residents who get health coverage through an employer. The result is that the MCHA assessments are borne by a shrinking number of payers in the individual market, the small-employer market, and the portion of the large-employer market that is not self-insured. Employers that are too small to self-insure see this as an unfair increased cost of insurance on them and their employees.

If Minnesota enacted an individual requirement to have insurance and guaranteed issue in the individual market, people who have chronic health conditions and do not have access to employer coverage would not need a mechanism like MCHA. Unless that time comes, MCHA will be needed and will need a stable and reliable funding mechanism. It would be preferable if a broader and fairer funding mechanism were available, and the legislature should continue to seek such a funding mechanism.

Chapter 6: Cost Recapturing Mechanisms

This section contains a list of possible finance mechanism options for the health care reform. These mechanisms include the realignment of existing funding mechanisms and the creation of new mechanisms in order to capture and maximize savings to reinvest within the health care system. This list is not meant to be exhaustive. The commission acknowledges that further discussion is necessary, especially in terms of the financial impact both on the cost of implementing these mechanisms and on the potential revenue generated. These recommendations are not listed in any prioritized order.

Recommendation 6.1: Establish a savings recapture assessment to be paid by health plan companies, health carriers, and third-party administrators.

This assessment would be determined by recapturing a percentage of the savings realized from health care cost containment initiatives that will create savings within the overall health care system. This recommendation is similar to the savings offset payment (SOP) that was recently established and assessed on health carriers and third-party administrators in Maine. In Maine, the Dirigo Board[25] calculates an "aggregate measurable cost savings" based on an analysis of savings that are deemed to be reasonably supported. The SOP is paid on a quarterly basis and is a percentage of claims paid during the relevant year by the health carrier, third-party administrator, and employee benefit excess insurance carrier. For 2006, the payment was 2.408 percent of annual paid claims for Maine residents, which resulted in $43.7 million.

Under this recommendation, the Department of Health, or another specified entity, would be required to measure the savings realized within the overall health care system due to identified cost containment efforts. A portion of the savings would be "recaptured" through an assessment on health plan companies and third-party administrators based on a percentage of claims paid during the relevant time period. The portion of savings to be recaptured would be established on a yearly basis up to 40 percent of the savings realized. The assessments collected would be used to expand health care coverage and other health care initiatives.

Recommendation 6.2: Increase the health impact fee on tobacco products.

Currently, the health impact fee is 75 cents per pack and 35 percent on tobacco products. For fiscal year 2007, the Department of Revenue estimated that $225.4 million would be collected. Increasing the fee by 25 cents for both categories would raise approximately an additional $57,200,000 in fiscal year 2009; $55,400,000 in fiscal year 2010; and $54,400,000 in fiscal year 2011. This recommendation also requires the establishment of a new fund in which the increase in the health impact fee would be deposited and dedicated to fund the Statewide Comprehensive Health Promotion Plan.[26]

[25] This board governs the Dirigo Health Agency, an independent state agency responsible for administering DirigoChoice, Maine's public/private subsidized health plan for small businesses and individuals, and other related state health care initiatives.

[26] Minnesota Department of Revenue, Tax Research Division, December 4, 2007.

Recommendation 6.3: Replace some or all of the existing loan forgiveness grants currently provided to primary care physicians under the health professional loan forgiveness program with a targeted Medical Assistance rate increase for primary care physicians who agree to practice in a designated geographic area.

The health professional loan forgiveness program is established under section 144.1501 and is administered by MDH. The current annual budget for the program is $1.295 million and is paid from the general fund, the state government special revenue fund, and the health care access fund. The program includes loan forgiveness for physicians who practice in designated rural areas or underserved urban communities, physicians who practice in pediatric psychiatry, physician assistants, APRNs, nurses, health technicians, pharmacists, and dentists who meet the eligibility criteria established for each occupation.

As an alternative to the loan forgiveness grant payments paid to physicians who practice in designated rural areas or underserved urban communities under the loan forgiveness program, it may be possible to provide enhanced MA reimbursement to physicians who meet specific criteria similar to those established under the loan forgiveness program. Physicians who agree to practice within a designated rural area or an underserved urban community would apply to DHS to receive an increased MA reimbursement rate that would be in effect for a time-limited period. Under this program DHS, in consultation with MDH, would specify the areas of the state where there is a need for primary care physicians. Any physician who would be willing to establish a practice within that area would receive this enhanced MA rate. The program would also permit the department to change the designated areas in order to address needs in areas of the state as they arise.

The enhanced reimbursement would need to be structured to comply with federal Medicaid regulations which, in general, restrict the use of Medicaid reimbursement for medical education. The program could, for example, provide a noneducation-specific increase to any physician who chooses to begin a practice within the designated areas, whether or not the physician is a recent graduate.

Recommendation 6.4: Create a community benefit pool to which hospitals and health plan companies would be required to contribute in order to retain their not-for-profit status.

This recommendation requires creating a "community benefit" pool to which hospitals and health plans would contribute in order to retain nonprofit tax-exempt status at the state level. This recommendation anticipates the significant reduction or elimination of the need for charity care and other hospital subsidized services that hospitals currently use to receive credit for community benefits and community care.

Currently, in order to qualify for nonprofit tax-exempt status, hospitals must meet a broad "community benefit" standard. Recent focus has been on whether nonprofit hospitals demonstrate community benefits in proportion to the value of tax exemptions. This has led to discussions on how to measure and quantify "community benefits." Last session, the legislature enacted a requirement for nonprofit hospitals to include in their annual reporting on health care cost information, the hospital's community benefit and community care in terms of total dollars and as a percentage of total operating costs (see Minn. Stat. § 144.699, subd. 5). An MDH estimate of "community benefit" provided by Minnesota hospitals in 2005 showed that the net total of community benefits provided was $607.2 million. This included charity care ($80.3 million), payment shortfall and taxes ($357.8

million), and other quantifiable community benefits ($235 million), minus disproportionate share hospital (DSH) payments. The estimated value of tax exemptions for the same period totaled $482 million.[27]

For nonprofit health plan companies, there are no established expectations to meet or retain nonprofit status other than the expectation that these companies will benefit the health of the state's residents as a whole, and not just the companies' enrollees (see Minn. Stat. §§ 62C.01, subd. 2, and 62D.01, subd. 2). Under this recommendation, a health plan company could contribute to a community benefit pool, which would meet the community benefits expectation to ensure nonprofit status.

Recommendation 6.5: Create a budget forecast mechanism that would recognize the savings from health care initiatives and recapture these savings to be used for health care purposes.

This recommendation would require the Commissioner of Finance, when preparing the budget forecast for health and human services programs administered by the Commissioners of Human Services and Health, to estimate any savings that would result from implementation of legislatively authorized initiatives to reduce health care costs. The commissioner would determine these savings by subtracting forecasted costs based on implementation of the legislative initiative to reduce health care spending from forecasted costs that would otherwise be incurred if the legislative initiatives were not implemented. The resulting cost savings could be appropriated to the Commissioners of Human Services and Health to fund ongoing or new initiatives to improve access to health care and the quality of the health care provided. The legislature should determine how such appropriations are to be spent after receiving this information from the Commissioner of Finance.

Recommendation 6.6: Require the Commissioner of Human Services to aggressively negotiate growth limits and cost controls in managed care contracts with health plans.

Last session, there was a legislative proposal to establish limits on annual growth of health plan premiums of approximately 6 percent. Based on this proposal, DHS provided a preliminary fiscal note that assumed that with premiums capped at an estimated 6 percent, the department could successfully negotiate a lower rate increase, 1 percent to 1.5 percent, for the managed care plans that contract with DHS. If reimbursement rates could be negotiated at this decreased amount, the projected savings would be approximately $7 million in fiscal year 2008, $24 million in fiscal year 2009, $45 million in fiscal year 2010, and $69 million in fiscal year 2011.

Recommendation 6.7: Ensure that the health care access fund is reserved for health care purposes that are not currently the responsibility of the general fund.

A separate health care access fund was established in 1992 as a special revenue fund in the state treasury. All revenue derived from the MinnesotaCare tax imposed under Minnesota Statutes, sections 295.50 to 295.57, and from the insurance premium tax imposed under 297I.05, subdivision 5, is required to be deposited into the health care access fund. Under section 295.581, "money in the health care access fund shall be appropriated only for purposes that are consistent with past and

[27] Minnesota Department of Health, Minnesota Hospitals: Uncompensated Care, Community Benefits, and the Value of Tax Exemptions, Table 6 and Table 7, January 2007. Appendix 2 of the report details the great variation on community benefits by hospital, from 1.3 percent to 32.6 percent of operating expenses among government hospitals, and from 1.5 percent to 19.9 percent of operating expenses among private nonprofit hospitals.

current MinnesotaCare appropriations…or for initiatives that are part of the…health care reform waiver submitted to the federal Centers for Medicare and Medicaid Services by the Commissioner of Human Services as appropriated in Laws 1995, chapter 234." In the past, there have been legislative proposals to either spend health care access fund money or transfer money to the general fund, for purposes other than for the health care reasons stated in statute. This recommendation simply reiterates the intent of the commission to ensure that these funds remain dedicated for the purpose of health care and that there is sufficient revenue to finance the MinnesotaCare program.

Chapter 7: New Cost Containment Initiatives

This section contains recommendations related to initiatives to achieve short-term cost containment as well as establishing long-term restructuring of the health care system. These recommendations combine different strategies in an attempt to contain costs and provide savings while increasing health care coverage and access to more Minnesotans.

Recommendation 7.1A: Require the establishment of an independent board to develop an evidence-based benefit set and design to ensure that the benefits covered are safe, effective, and scientifically based. This recommendation also requires that in developing this benefit set, specific preventive care services, early diagnostic tests, chronic care coordination services, and prescription drugs are identified as cost effective for purposes of establishing cost-sharing requirements that encourage their use. The board shall use the evidence-based benefit set as the basis for developing a limited number of standardized health insurance policies to be sold through the health insurance exchange described in Recommendation 3.2 of this report.

Recommendation 7.1B: Require the Commissioners of Health and Human Services, in collaboration with the Health Advisory Council, the University of Minnesota, and the ICSI, to develop an evaluation process for new procedures, medications, and technologies to ensure that coverage is provided only for those procedures, medications, and technologies that are safe, effective, and scientifically based.

Background

The commission acknowledges the need to create evidence-based benefit sets to ensure that care is the highest quality and delivered in the most efficient manner. The commission also recognizes the need to establish an assessment process for new procedures, medications, and technologies to ensure that these are covered by the state or by the private insurance market only if there is scientifically based evidence indicating their safety and cost effectiveness. This would make coverage and policy decisions regarding the use of our health care resources more accountable and value based and reflective of both the best scientific evidence available and the preferences of those affected by these health policy decisions. That being said, the commission acknowledges that this is no easy task. To develop such a valued based benefit set and assessment process, the legislature should build on existing sources and efforts by organizations and groups that have the expertise to devote to this endeavor.

Past and Current Efforts

In 2005, Minnesota created the Health Services Advisory Council (HSAC) to advise DHS on evidence-based decision making and on designing benefit and coverage policies for the state health care programs (see Minn. Stat. § 256B.0625, subd. 3c). The council consists of ten physicians, including the medical directors of health plans; a chiropractor; a nurse practitioner; and a consumer. One of the central roles of the HSAC is to advise DHS on clinical coverage policy decisions using available scientific evidence, professional standards, expert opinions, safety, and clinical effectiveness.

Other key sources that are available for reference are as follows:

- Medicaid Evidence-Based Decisions (MED) Project: This is a collaboration of state Medicaid programs housed at the Center for Evidence-Based Policy at Oregon Health Sciences University. The MED Project creates reports and makes recommendations based on clinical evidence, provides staff support, and facilitates knowledge sharing between states. Minnesota is part of this collaboration.
- AHRQ/Academy Health Medicaid Medical Directors' Learning Network: This is a forum for the sharing of research and experience among medical directors in state Medicaid programs across the country.
- Institute for Clinical Systems Improvement (ICSI): This is a locally based, nationally recognized collaboration of health care organizations that identifies the best clinical practices using an evidence-based approach that emphasizes the critical evaluation of scientific evidence and facilitates their implementation. DHS is a member of ICSI.
- University of Michigan Center for Value-Based Insurance Design: This center was established in 2005 to develop, evaluate, and promote value-based insurance initiatives in order to ensure efficient expenditure of health care dollars and maximize benefits of care.
- The State of Washington's Health Technology Assessment program: This program was created in 2006 to ensure that health technologies purchased by the State of Washington are safe and effective, and that coverage decisions made by various state agencies are consistent, transparent, and based on evidence.
- The State of Oregon's Prioritized List: This is a list that ranks health care services in order to guide decisions regarding the allocation of funding for Medicaid and SCHIP and to make coverage decisions more transparent and accountable. The methodology reflects the best evidence available on clinical effectiveness and cost as well as the preferences of those affected by these policy decisions.
- The National Institute for Health and Clinical Excellence (NICE): This is an independent organization responsible for providing guidance to the United Kingdom national health system on the promotion of good health, the use of new and existing medicines, technologies, treatments and procedures, and the appropriate treatment and care of specific diseases and conditions.

Details of the Recommendation

The legislature shall establish an independent board to define a cost-effective evidence-based benefit set. This board shall be a public/private entity with members to be appointed by the governor and legislature. The board members should not be in a position to directly benefit from the board's decisions and a portion of the members should have expertise in benefit design.

The board should contract with an independent entity, such as ICSI, to provide scientifically based standards to be used to establish the benefit set and design. This benefit set and design will serve as the minimum benefit set to be offered through the health care exchange. It will also serve as the standard for determining whether employer coverage would qualify for subsidies in order to meet the established affordability standard. Finally, it would be the standard that must be met if a mandate requiring all Minnesotans to obtain individual health coverage went into effect.

The benefit set should include evidence-based preventive services with no cost-sharing requirements. The benefit set should also include ICSI-designated evidence-based outpatient care for asthma, heart disease, diabetes, and depression with no cost-sharing requirements, or with minimal cost-sharing requirements that do not impose an economic barrier to access to that care.

The benefit set, as well as the services that should be offered with no cost-sharing requirements, should be reviewed on an ongoing, periodic basis, and the benefit set should be adjusted to ensure a benefit design that is current, safe, effective, and scientifically based. In establishing the benefit set, the board should take into consideration cultural, ethnic, and religious values and beliefs to ensure that the benefit set recognizes the needs of all residents.

The Commissioners of Health and Human Services, in collaboration with the identified groups, shall develop a systematic evidence-based assessment process to evaluate and establish guidelines on the use of new and existing procedures, treatments, and technologies, including, but not limited to, medical devices, diagnostic techniques, and surgical procedures. This process should include an independent committee or nonregulatory board to select technologies to be assessed. The assessment must be conducted by an independent entity and must consider safety, health outcome, cost, and effectiveness, based on scientific evidence. A determination must be made, based on this assessment, as to whether the technology should be covered within the state health care programs. This assessment could also be used as a recommendation as to whether health care plans should provide coverage.

Recommendation 7.2: Develop a patient-directed decision-making process to be used within the state health care programs.

Background

Patient-directed decision making involves an interaction with patients to assist the patient in arriving at an informed, value-based health care decision when there is no clearly indicated "best" therapeutic option and the options that are available have features that each patient may value differently. These decisions are what John Wennberg and colleagues at the Dartmouth Atlas HealthCare Project have referred to as "preference sensitive" decisions because the best treatment option depends on the patient's values or preferences for each option.[28] Some examples of "preference sensitive" decisions include options in treating abnormal uterine bleeding, benign prostate enlargement, chronic back pain, menopause, and early stage breast and prostate cancers. To ensure that the options chosen by patients are based on an informed decision, a patient-directed decision making style of counseling has been used that provides information to the patient through the use of decision support aids. A number of evidence-based decision aids have been developed and are available to aid, rather than replace, patient-provider interaction. They can be either self administered or provider administered in one to one or group sessions. The media of delivery varies from print to internet presentations.

[28] J.E. Wennberg and M.M. Cooper, "The Surgical Treatment of Common Diseases" *Dartmouth Atlas of Health Care 1998*, p. 108-111.

Past and Current Efforts

Despite the evidence of the benefits of using decision aids, their use has yet to become prevalent. However, the use of decision aids has been evaluated through clinical trials in Canada and England.[29] HealthPartners has offered a shared decision-making program to its enrollees since 2005. This program supplements clinic-based counseling by identifying and addressing gaps in knowledge and incorporating patient preferences into the decision-making process. Enrollees who are already participating in HealthPartners health promotion, disease management, and medical and behavioral case management programs automatically receive shared decision-making assistance. Other enrollees can proactively access these services by request.

Details of the Recommendation

In developing this process for enrollees of the state health care programs, DHS could require the managed care plans that contract with the department to encourage patient involvement by providing patient-directed decision-making tools to their enrollees. For enrollees who do not receive services through a managed care plan, the department could require primary care providers to (1) encourage their patients who are deciding between two or more clinically acceptable options, to use such tools; and (2) to facilitate the use of patient aids that are free and publicly available.

Recommendation 7.3: Develop a midlevel dental practitioner to work within a collaborative agreement with a licensed dentist.

Background

Oral health has been described as one of the "single greatest unmet health care needs" in the country. Dental decay is the nation's most common chronic disease—five times more common than asthma. Without access to basic dental care services, dental care for many is postponed until symptoms become so acute that care is sought in the emergency room or leads to far worse health conditions, even death. The progressive nature of dental disease coupled with the lack of access, especially among low-income families, can significantly diminish the general health of these individuals. Evidence is mounting that suggests that individuals with periodontal disease may be more at risk for heart disease, stroke, and pneumonia, and have twice the risk of having a fatal heart attack.[30] This lack of access is wasteful and costly to the health care system. According to DHS, only 42 percent of public program enrollees receive dental care and the greatest need is for access to restorative services. Waiting lists for appointments in many community clinics can be several months and up to eight months in some rural clinics. The cost of investing in preventive dental care, such as regular dental screening and early intervention as well as adequate access to restorative procedures, is low compared to the possible savings that would be realized within the health care system. According to the National Institute of Dental Research, every $1 spent on preventive care can save $4 in dental costs**.**

The concept of a midlevel dental practitioner is not new. Precedents for this type of practice exist in New Zealand, Canada, parts of Europe, and over 40 other countries. An example of the successful use of dental health aide therapists can be found in the Alaska Dental Health Aide initiative. As part

[29] Annette O'Connor, Hilary Llewellyn-Thomas, and Ann Barry Flood, "Modifying Unwarranted Variations In Healthcare: Shared Decision Making Using Patient Decision Aids" *Health Affairs*, October 2004.
[30] U.S. Department of Human Services, The National Institute of Dental and Craniofacial Research, National Institutes of Health, *Oral Health in America: Report of the United States Surgeon General*, 2000.

of this initiative, dental health aide therapists are trained to perform cleanings, fillings, and uncomplicated extractions in addition to a wide range of preventive services.

Past and Current Efforts

The need for improved access to dental care services has been an issue that the legislature has struggled with for years. Last year the legislature appropriated $400,000 to fund oral health innovation grants to organizations to provide access to oral health services for low-income and uninsured individuals. Furthermore, in 2005 the legislature was successful in removing the $500 annual dental services benefit limit for adults in state health care programs. In 2006 the legislature was also successful in making the critical access dental provider reimbursement rate increase a forecasted expenditure, ensuring that this increased rate will be sustained. While this has helped, it is still not sufficient to fully address the access crisis in dental health. Finally, in 2002, the legislature expanded the scope of practice for dental hygienists working within a collaborative agreement with a dentist to perform limited oral services at specified health care facilities serving underserved populations. Again, while this has helped, the lack of access to restorative services, which cannot be provided by these dental hygienists, is still a problem.

Currently, Metropolitan State University is developing a master's-level program for an Advanced Dental Hygiene Practitioner and hopes to begin enrolling students in the program by 2009.

Details of the Recommendation

A midlevel dental practitioner would be educated at the master's degree-level (over a two year course of study) to treat patients by providing diagnostic, preventive, therapeutic, and restorative dental services with a primary focus on the underserved. The midlevel dental practitioner would work under general supervision and under a collaborative agreement with a licensed dentist, similar to the arrangements that physicians assistants and advanced nurse practitioners have with physicians.

Recommendation 7.4: Explore the feasibility of a Community Paramedic Pilot Project.

Background

The community paramedic concept has been used in other states and countries, including Alaska, New Mexico, Nova Scotia, and Australia. This concept involves the use of emergency medical personnel to provide certain services in designated areas where there is a shortage of health care personnel and facilities. The Alaska program has been in existence for the past 50 years and is a part of Alaska's community health aide/community health practitioner program. The services provided by emergency medical personnel include 24-hour emergency care, acute care, urgent care, prenatal care, childbirth and newborn care, preventive services, chronic care follow up, lab services, home health care services, and IV medications. The New Mexico program was established through a federal grant. This program started with emergency medical personnel as the backbone, and the services they provided were wound care, including suturing, immunizations, prenatal care, disease management for congestive heart failure, hypertension, diabetes, and the treatment of lung problems, dehydration, and infectious diseases.

Past and Current Efforts

In July of 2007, MDH Office of Rural Health and Primary Care, Mayo Clinic Medical Transport, and the Healthcare Education Industry Partnership joined with the Nebraska Office of Rural Health,

Dalhousie University in Nova Scotia, and other entities to form the Community Health Care and Emergency Cooperative. The purpose of the cooperative is to develop the community paramedic concept to serve rural and remote communities. Furthermore, the North Central EMS Institute has developed a curriculum for a community paramedic program and a corresponding pilot project that should be ready to implement this spring. These potential pilots involve a tribal ambulance service and a critical access hospital-based ambulance service.

Details of the recommendation

This recommendation would require MDH to explore the feasibility of the community paramedic concept for Minnesota, with a comparative analysis of this role and the role of the community health worker,[31] and present recommendations to the legislature by January 15, 2009. This concept would use paramedics and emergency medical technicians to deliver preventive and some primary care. The department would examine issues related to the preventive and primary care services that could be provided, quality of care, curriculum development, and possible pilot project implementation.

Community paramedic services could include: outreach, wellness, health-screening assessments, health teaching, immunizations, disease management, recognition of mental health issues and making related referrals, wound care, safety programs, and functioning as physician extenders in rural clinics and hospitals.[32]

[31] MA, GAMC, and MinnesotaCare cover care coordination and patient education services provided by a community health worker, if the community health worker has received a certificate from the MnSCU approved community health worker curriculum or has at least five years of supervised experience with a physician, registered nurse, or advanced practice registered nurse. Community health workers are required to work under the supervision of a physician, registered nurse, or advanced practice registered nurse.

[32] See the "Community Paramedic" handout from the Community Health Care and Emergency Cooperative provided to the Legislative Commission on Health Care Access

Chapter 8: Health Care for Long-term Care Workers

Recommendation 8.1: Appropriate funds to the DHS to obtain the specific data needed to determine the cost of a future rate increase to long-term care employers that would be dedicated to the purchase of employee health insurance in the private market.

Background

The long-term care industry has three features that generally result in reduced health care coverage. First, many workers are relatively low-paid and are simply unable to afford coverage when it is offered. Many workers are part-time and often not working enough hours to meet minimum qualifications for coverage. Finally, the industry is subject to high turnover, so at any one time a large percentage of employees are in the waiting period prior to qualifying for coverage.

A 2002 report from MDH, entitled "Employer-Sponsored Health Insurance in the Minnesota Long-Term Care Industry" concluded that, while a large percentage of long-term care employees work for employers that offer health insurance benefits, a relatively small percentage of employees take advantage of this benefit. The study found that 81 percent of long-term care employers (that employ 94 percent of the workers in the industry) offer health insurance benefits. However, only 68 percent of eligible long-term care employees were enrolled (the take-up rate) and only 36 percent of all employees were covered (the coverage rate). A nonscientific survey of long-term care employers conducted in September by the Long-term Care Workers Working Group arrived at similar conclusions. For all of private industry, the MDH study found that 87 percent of workers were employed by businesses offering coverage, the take-up rate was 88 percent, and the coverage rate was 62 percent.

Long-term care industry workers who are not insured through their employer may be insured through privately purchased coverage, as a dependent on another policy, or through public programs. Data from the Current Population Survey (CPS) for 2006 and 2007 indicates that 9 percent of long-term care workers are not insured through any of these options. It is clear that a significant percentage of long-term care workers are uninsured, and that the realities of the industry—low pay, the prevalence of part-time work, and high turnover—make it unlikely that the remaining uninsured long-term care workers will be able to obtain employer-based coverage without some sort of state intervention.

Past and Current Efforts

Recent cost-of-living rate increases for long-term care employers have attempted to address this problem by requiring that a substantial percentage of these rate increases be spent on employee wages and benefits, including health care benefits. However, given the rapid increase in health care costs in recent years, it does not appear that this approach has done anything beyond helping employers pay ever-increasing health insurance premiums. It is doubtful that any money has been available through this mechanism to allow employers to improve coverage plans or expand coverage to more employees.

Legislation has also been introduced in recent years to address this problem by expanding MinnesotaCare eligibility for long-term care workers. This legislation has not been adopted.

Details of Recommendation

A rate increase to long-term care employers dedicated to the purchase of employee health insurance in the private market is an attractive option because the majority of these rate increases would be paid by the Medical Assistance (MA) program, and one-half of the MA payments would be paid by the federal government.

The Long-term Care Workers Working Group discussed three options for a minimum level insurance product, as follows:

(1) The benefit package provided to state employees. Employee coverage currently costs $432.16 per month, or $5,185.92 per year. Dependent coverage is $838.70 per month, or $10,064.40 per year. The annual cost for employee and dependent coverage is $15,250.32.

(2) The benefits provided to MinnesotaCare enrollees. These benefits currently cost $350 per person per month, or $4,200 per person per year. One shortcoming of this benefit package is the $10,000 limit on hospital coverage for some adult enrollees.

(3) The benefits provided under an "average" private market health insurance product, but with a deductible limited to $100 per person. The Commerce Department roughly estimated the costs of an average small group medical premium at $300 to $400 per person per month in 2006, ranging from a low of $200 per month for a child up to $750 per month for a person aged 60 or older. Limiting the deductible to $100 would increase premiums by about 10 percent. An average plan might include a deductible of $300 per person and $900 per family, an out-of-pocket maximum of $2,500 per person, and full coverage of most in-network services, with co-payments for emergency room outpatient care and prescription drugs.

Premium cost sharing, waiting periods for eligibility, and other parameters under the three options would be identical to those under the state employees' health plan. Full-time employees would pay 0 percent of the individual premium and 15 percent of the dependent premium. Part-time employees would pay a higher percentage of premiums on a sliding fee scale according to the number of hours worked. Part-time employees would need to work at least 32 hours per pay period to be eligible for insurance benefits. The waiting period for new employees to qualify for coverage would be 35 days.

The working group also discussed incremental steps to be considered if the lack of funding or other impediments prevent immediate adoption of a rate increase dedicated to health insurance costs. One option discussed was a targeted, limited rate increase that would assist some long term care employers with health insurance issues but would not be a broad solution to the problem. This rate increase could be modeled after the long-term care employee scholarship rate, which provided a per diem payment to employers for employee scholarship costs. This option could provide useful results that would be helpful in developing a broader program.

DHS has informed the working group that it could not complete a fiscal note on a broad insurance initiative because it needed specific data on the number of full-time and part-time workers; their claim patterns and histories; the current levels of employer investment in health insurance; and a specific identification of which employers would be included. Providing an appropriation for needed analysis and data collection is designed to ensure that in future years, very specific data will be available on which to base a broad initiative to insure long-term care workers.

Chapter 9: Continuing Health Care Restructuring

The commission acknowledges that to provide every Minnesotan with access to affordable health care is a continuous process of ongoing adjustments and improvements as changes are implemented and new approaches are explored. The commission also recognizes that in order to achieve a smooth transition and success in reforming the health care system it must be viewed as a changing continuum rather than separate fragmented components. To achieve this goal, the commission will continue to evaluate the process and make all necessary adjustments, as well as continue to openly discuss and evaluate all ideas and approaches to ensure success in achieving high-quality, affordable, and accessible health care for all Minnesotans. With this in mind, the commission makes the following recommendations:

Recommendation 9.1: The legislature should take a global view of the health care system when recommending changes, in order to increase funding flexibility between different health care sectors, avoid unintended consequences, assess the total impact of changes, and reduce cost shifting.

Background

The Bridging the Continuum Working Group concluded that one of the fundamental flaws in our health care system is fragmentation. The financial and functional isolation of public health, health insurance, social and community supports, and long-term care from each other results in a variety of problems, including cost shifting between parts of the system and differences among the sectors regarding eligibility, services, and funding.

Details of Recommendation

The working group concluded that it will not be possible to achieve the state's health care goals by concentrating only on one part of the system, but, instead, bridges must be built between the sectors so that money may be used earlier in one sector for prevention and health maintenance in order to prevent the need for high-cost treatment and institutional care later on, often paid for by another sector.

Achieving this bridging will require policymakers to keep in mind a big picture view of the entire continuum of care, realizing that all parts of the system are interconnected and interdependent. The public health system affects the commercial health insurance system, which in turn affects the long-term care system. It is important to understand how each component of the health care system fits into the whole and how actions in one part have consequences in the other parts. For example, a health care reform strategy that saves money in one sector may actually produce higher costs in another sector. Health care reform strategies should be based on a global view of costs, savings, and the potential for cost shifting across the entire health care system and continuum of care.

Taking this global view will require uniform data collection and reports from various state agencies and counties that more accurately track individuals' health status, costs, and services in a consistent way throughout the continuum of care and in the different programs and sectors. It will also require policymakers to ask the following types of questions: Do we understand the impact of a proposed action on all parts of the entire health care system, on government budgets, and on costs to individuals, businesses, and the community? Does a proposal reduce overall costs, or just shift costs to another part of the system? Are there incentives not to serve the people who have the greatest

needs or are the most difficult to serve? Do the reform proposals offer the opportunity for transformational change across the entire health system and an improved return on investment of health care dollars over time?

Recommendation 9.2: The commission should work to identify gaps and deficiencies in the health care system and make recommendations on how to create a more individual-centered, seamless health care continuum that allows a smooth transition between providers and services and avoids unnecessary fragmentation.

Background

The Bridging the Continuum Working Group recommended the following guiding principles for health care reform strategies: keep the client and family at the center of the system; integrate and coordinate services under a single, client-centered plan; eliminate gaps in services and make it easy for clients to make smooth transitions between programs, services, and providers; and do more upstream prevention to prevent problems from developing or getting worse.

Past and Current Efforts

A number of health care reforms for clients of public programs are in various stages of implementation. They provide services to the elderly, persons with mental illness, a disability, or complex health care needs. The programs include Minnesota Senior Health Options (MSHO), Minnesota Disability Health Options (MnDHO), Mental Health Preferred Integrated Networks (PINS), Special Needs Plans – Basic Care (SNP-BC), and county-based purchasing. These reforms include, in some instances, service coordination, commingling of funds from different government programs into a single funding stream, and other components necessary to move towards a seamless health care system. These models need to be expanded as part of the effort to integrate funding and services.

Details of Recommendation

In addition to expanding existing models, there are many steps the commission can consider in the effort the build a seamless system. There needs to be greater consistency in eligibility criteria and service options in all public programs serving the elderly and persons with chronic conditions, disabilities, mental illness, or complex health care needs. Planning needs to occur to develop and implement phased-in use of a streamlined, standardized needs assessment, service menu, and eligibility and enrollment process for all public clients.

In addition, a periodic, statewide gaps assessment is necessary to determine service capacity and availability in all regions of the state. To reduce or avoid gaps in care, a continuous planning process along the entire health care continuum needs to be developed, so that the system feels seamless to the consumer. The system should reflect the reality that most people's needs change over time, and they must transition between and among different types of service, levels of care, and health care payment sources.

Recommendation 9.3: Savings in the long-term care system that can be achieved by providing early intervention services to prevent chronic illnesses later in life should be taken into consideration when calculating long-term care costs. The Departments of Human Services and Finance shall recommend changes in state budgeting processes so that, when fiscal notes are being prepared, the impact of proposed legislative changes across traditional budget boundaries is assessed and resources are allocated across those boundaries.

Background

It is generally accepted that increased spending up front on public health, prevention, early intervention, and intensive care coordination will reduce the rate of growth in health care costs in the future. Perhaps the greatest opportunity for reducing costs is in the long-term care and continuing care sector of the state budget that serves the elderly and persons with disabilities. However, many of the activities that could have the greatest impact on these costs must be undertaken in other sectors of the health care system, such as public health or private health insurance. Given the incentives and funding streams built into our current system, it is currently difficult to recognize the impact that actions in one sector have on the other sectors or to recognize future cost savings that will result from investments made now.

Details of Recommendation

Bridging across the public and private sectors of health care financing in order to control overall costs will require rethinking the traditional roles and financial contributions of government, individuals, employers, and the community. Private health insurance costs can be reduced through public health efforts to promote better health in the entire population. Similarly, long-term care costs in the public sector can be reduced through better prevention, health promotion, and chronic care management provided under private health insurance. Getting to the point where these costs and savings are recognized across the various public and private financing sectors is a long-term goal.

A shorter range goal is to improve recognition in the state budget of these interrelationships. Currently, some effort is made to recognize direct costs and savings in one state budget area that are the direct result of modifications made in another budget area. For example, reduced spending on state "waiver services" programs has been recognized as increasing spending in regular medical programs. The state fiscal note process also needs to do more to recognize the immediate secondary impact and the long-term impact of state actions. For example, public health initiatives, smoking bans, and other efforts can have an immediate, but not directly measurable, effect on reducing health care costs. Likewise, these initiatives, and many other state actions, can have an impact on budgets well into the future that are not now recognized in the budget process.

Ways to recognize these impacts need to be explored with the long-term goal of allowing expected long-term savings to be invested upfront to make additional short-term investments that can generate even more savings over the long haul. For the short term, better reporting of estimated secondary and long-term costs and savings would set the stage for actually recognizing these impacts in the fiscal note process sometime in the future.

Recommendation 9.4: The legislature and the Legislative Commission on Health Care Access shall continue to study the option of the state transitioning to a single-payer style health care delivery system.

Using the work that began during the past interim, the legislature and the commission should continue to study the development of a single-payer system for the state of Minnesota. To understand the impact of a transition from the current health care delivery mode, the commission should evaluate projected costs, savings, and changes to the delivery of health care services.

Recommendation 9.5: The Department of Health and the Council of Health Boards are encouraged to review existing statutory and regulatory occupational licensure requirements and the scope of practice limitations created by different licensure levels to identify situations in which health care professionals could provide an expanded level of care.

The legislature should encourage a review of occupational licensure requirements to identify and recommend changes to any requirement that may be prohibiting health care professionals from providing services that they are professionally capable of providing, especially when this care could be provided in a safe and effective manner at lower costs.

Chapter 10: Payment Reform

This section contains recommendations that were identified by the Health Care Transformation Task Force related to health care payment reform. The Health Care Transformation Task Force was convened by the governor, in response to legislation passed by the 2007 Legislature (Laws of Minnesota 2007, ch. 147, art. 15, sec. 21). The task force is required to develop and present to the governor and the 2008 Legislature, a plan to transform the health care system to improve affordability, quality, access, and the health status of Minnesotans.

Recommendation 10.1: Implement Payment Reform Levels 1 and 2, as developed by the Transformation Task Force.

Background

The current health care payment structure does not adequately meet the needs of patients and health care providers. The current payment structure is episode driven and places little or no emphasis on prevention, care coordination, or quality. This system centers on the "tyranny of the visit," pressures providers to increase volume and to see more patients in less time, and undervalues the services delivered by primary care health care providers. In too many instances, these factors result in inappropriate health care services being provided to patients and unnecessary health care spending.

The transition to a payment system that rewards, rather than penalizes, providers who adopt innovative methods of health care delivery that result in higher quality and lower cost will involve major shifts in the ways that most health plans, providers, purchasers, and patients do business.

A reformed payment system must provide all players within the health care system with incentives to improve quality, reduce costs, and engage consumers in the decision-making process. The commission recommends implementing Levels 1 and 2 of the payment reform developed by the Transformation Task Force, which are detailed below. We must begin the process of linking payment for care to quality, which Level 1 achieves. Level 2 continues with the quality mechanisms from Level 1, but moves the state forward in the development of health care homes (see also the health care home and provider education section of this report). Providers will be paid a care coordination fee once they demonstrate they have the infrastructure and systems needed to function as an effective health care home.

Goals

The purpose of these reforms is to restructure the health care payment system to support and encourage evidence-based, high-value health care. The goals of this recommendation are as follows:

- Providers should be accountable for, and compete, based on the cost and quality of care they deliver for the population they care for
- Individuals should be empowered with information on the quality and cost of care, and should be responsible for choosing providers and services based on value, with minimal restrictions on switching providers
- Payment systems should support improved coordination of care (health care home concept)
- There should be full transparency and vigorous provider competition on price and quality

- A sufficient number of purchasers and payers should support the restructured payment system in order to achieve and sustain the "critical mass" needed to make the reform successful

Details of the Recommendation

This section details Levels 1 and 2 of the payment reforms as identified by the Transformation Task Force.

Payment systems should hold health care providers accountable for quality, care coordination, and the total cost of care. To achieve this, it is recommended that payment reform occur in two stages: Level 1 and Level 2. Some providers may be ready immediately to participate in Level 2; others may only be ready for Level 1.

Level 1 of payment reform will involve making payments to providers that explicitly depend on the quality and efficiency of care they provide:

a. Providers meeting specific targets (or who show a significant amount of improvement over time) will be eligible for these quality/efficiency-based payments. These payments will be incorporated into existing payment systems in a budget-neutral way, most likely as withholds.
b. The quality/efficiency measures will be based on the measures defined in Recommendation II-B2 of the Health Care Transformation Task Force report, with a priority on measures of outcomes, rather than processes, wherever possible.
c. For primary care providers, the quality measures will focus on preventive services, coronary artery and heart disease, diabetes, asthma, chronic obstructive pulmonary disease, and depression.
d. For specialty care, where the availability of quality measures is more limited, specialty societies have developed quality indicators that can be measured and reported publicly, and specialists should be encouraged to rapidly develop additional quality indicators.
e. Hospital payments will also be adjusted for quality and efficiency using existing measures where available.
f. Other indicators of care quality and efficiency should be incorporated where appropriate, such as the existence of care infrastructure (e.g., electronic record systems), collection and internal/external reporting of results, measures of efficiency on specifically defined procedures, measures of the overall cost of care for individuals, and adjustments to payment rates to reflect the characteristics of the population served.

Level 2 of payment reform will involve providers assuming greater responsibility for coordinating care for patients, particularly those with chronic conditions.

a. Providers at Level 2, including those serving as "medical homes" (see Recommendation III-C4 of the Transformation Task Force report and the health care homes and provider education section of this report), will receive "care management fees" for monitoring and managing care. The amount of the care management fee should be adjusted for the severity/risk of the patients served (e.g., higher fees would be paid for patients with multiple, complex chronic illnesses, and lower fees would be paid for healthy patients who require only preventive care).

b. Providers will need to meet specific standards, including having specific types of care management systems in place, to be eligible for care management fees. Initially, the standards likely will be based on processes, but they should quickly evolve to be based on cost and quality results.

c. Although the care management fee creates an additional payment to providers, it is expected that increased use of care management will result in less use of acute care services and overall cost savings.

d. The quality/efficiency-based payments in Level 1 would also be included in Level 2 and could be modified to ensure that there are adequate financial incentives for providers receiving the care management fee to reduce the total cost of care. Providers whose quality or efficiency does not enable them to qualify for the quality/efficiency-based payments under Level 1 would not be eligible to receive the care management fee.

e. The severity/risk adjustment system for the care management fees should consider the additional time and resources needed by patients with limited English-language skills, cultural differences, or other barriers to health care.

f. Care management fees could be phased in, focusing first on the chronic disease populations where the largest financial savings could be achieved relatively quickly (e.g., by reducing hospital admissions and readmissions for patients with chronic illnesses).

Chapter 11: Universal Coverage

Recommendation 11.1: Enact a contingent requirement for individual responsibility, requiring all Minnesota residents to have health coverage, only if increased affordability, cost containment, and voluntary efforts fail to achieve the goal of universal coverage. The requirement should be triggered if the following phase-in schedule of interim goals is not met:

- **94 percent insured by end of fiscal year 2009**
- **96 percent insured by end of fiscal year 2011**
- **97 percent insured by end of fiscal year 2012**
- **98 percent insured by end of fiscal year 2013 and thereafter**

If any one of these goals for fiscal year 2011 or later is not met, as determined by the Commissioner of Health, the individual responsibility requirement would automatically become effective 12 months later.

Studies show that persons with health coverage are less likely to put off needed care and more likely to appropriately use medical services (e.g., clinic vs. emergency room vs. preventive care). Increased costs have led to more cost sharing through co-pays and deductibles. Escalating premiums are causing many individuals and businesses to seriously consider dropping their health coverage. In recent years, the movement to ensure that all Minnesotans have access to affordable, comprehensive health care coverage has received growing supporting from a myriad of parties and is the charge of this commission.

Past Efforts

In 1992, Minnesota enacted an individual mandate, requiring every Minnesota resident to have and maintain health coverage from a public or private source, beginning July 1, 1997. It was repealed in 1995, before it would have gone into effect.

Efforts by Other States

In 2006, Massachusetts enacted an individual mandate for all individuals 18 years and older, which went into effect July 1, 2007.[33] State income tax returns require proof of health insurance coverage, and those that fail to comply will face tax penalties. Preliminary overall results show a significant increase in the number of persons who have coverage. The state has recently indicated that 60,000 residents will not face penalties for being uninsured, because the state cannot afford to extend subsidies to them and coverage would be unaffordable to them without a subsidy.

By comparison, instead of enforcing its individual mandate immediately, Vermont's mandate will not go into effect unless the state's uninsured rate remains above 4 percent in 2010.[34] The state

[33] Mass. Gen. Laws, ch. 111M § 2 (2007); E. Haislmaier and N. Owcharenko, *The Massachusetts Approach: A New Way to Restructure State Health Insurance Markets and Public Programs.* 25 Health Affairs 6, 1580-1590 (November/December 2006).

[34] Vt. Stat. Ann. tit. 2, § 902(a)(3)(D) (2007). A Joint Legislative Commission will determine the needed analysis and criteria for implementing a health insurance requirement by January 2011 if less than 96 percent of Vermonters have health insurance by 2010.

continues to promote health coverage through social marketing, outreach efforts, and market reforms in the meantime.

Efforts Needed in Minnesota to Meet the Phase-in Goals

Progress toward getting everyone covered must be focused on affordability and accessibility. Those who have coverage must have reasonable access to care where they live at a price they can afford. That includes affordability for those who currently have insurance (and the underinsured) so that they can maintain adequate coverage.

The state should use social marketing, outreach at a variety of venues, and other tactics to reach out to all uninsured Minnesotans. The effectiveness of various approaches should be measured, best practices implemented widely, and accountability for progress emphasized. Special efforts with measurable goals should be targeted at key groups of the uninsured such as small businesses and their employees, persons without access to employer-based coverage, low-income persons eligible for public programs of coverage, older pre-Medicare low-income persons, etc. Implementation of recommendations to achieve cost containment should proceed and contribute to progress in reducing the percentage of uninsured Minnesotans.

The goals for achieving the target levels of coverage will need to be based on a definition of the level of coverage that is acceptable to be considered insured. This should be based on coverage that is affordable and cost-effective.

If the individual responsibility requirement is triggered, it will be appropriate to consider also implementing a merger of the individual and small-employer markets, with guaranteed issue and community rating in the merged market.

Failure to comply with the individual responsibility requirement will need to be enforced by a meaningful and fair penalty.

Appendices

Appendix 1: Working Group Members

SENATOR LINDA BERGLIN, 61
Senator Paul E. Koering, 12
Senator Tony Lourey, 08
Senator John Marty, 54
Senator Julie Rosen, 24

REPRESENTATIVE TOM HUNTLEY, 07A
Representative Jim Abeler, 48B
Representative Steve Gottwalt, 15A
Representative Diane Loeffler, 59A
Representative Paul Thissen, 63A

85TH LEGISLATIVE SESSION

THE LEGISLATIVE COMMISSION ON HEALTH CARE ACCESS

GOAL

"The Legislative Commission on Health Care Access shall make recommendations to the legislature on how to achieve the goal of universal health coverage as described in section 62Q.165. The recommendations shall include a timetable in which measurable progress must be achieved toward this goal. The commission shall submit to the legislature by January 15, 2008, the recommendations and corresponding timetable."

SUBCOMMITTEE WORKING GROUPS

1. Subcommittees will each submit recommendations related to how their respective issues will improve the quality of the health care system for consideration by the full commission.
2. The commission co-chairs will appoint subcommittee co-chairs and members. Below is an initial list of members for each working group. The commission co-chairs may appoint additional members as necessary.
3. Each working group will include a combination of legislators and private or nonprofit sector advocates with expertise or interest in that area.
4. The commission co-chairs will outline the scope for each subcommittee and assign a deadline for final recommendations to be submitted to the commission.
5. Initial subcommittee working groups include:

    - Cost Containment: Identify Health Care Costs/Savings
    - Cost Containment: Restructure The Health Care System Through the Identified Savings
    - Development of New Cost Containment Strategies
    - Public Health
    - Insurance Market Reform
    - Health Care for Long-term Care Workers
    - Single Payer Health Care

COST CONTAINMENT: IDENTIFY HEALTH CARE COSTS/SAVINGS

Members:

Senator Tony Lourey, co-chair

Rep. Erin Murphy, co-chair

Senator Kathy Sheran

Senator Betsy Wergin

Rep. Julie Bunn

Rep. Maria Ruud

Rep. Tom Huntley

David Doth, REM Minnesota

Dr. George Schoephoerster, CentraCare Health Plaza

Doug Hiza, Blue Cross and Blue Shield of Minnesota

Lee Greenfield, Hennepin County

Jim Meffert-Nelson, Minnesota Optometric Association

Doug Wood, Mayo Clinic

Jim Fries, Stanton Group

Ghita Worcester, UCare Minnesota

Sanne Magnan, ICSI

Dr. Brian Rank, HealthPartners

Dick Pettingill, Allina

Cathy VonRueden, St. Mary's Duluth Health System

Mark Skubic, Park-Nicollet

Jonathan Watson, MN Association of Community Health Centers

Bob DeBoer, Citizens League

Mary Chesney, MN Nurses

Scope:

- Incentive payments, regulatory changes, and licensing law changes that will result in better health
- Correct flaws in the marketplace that lead to inefficient use of resources by creating a reimbursement system structure that is less expensive, by rewarding quality rather than volume of procedures
- Development of a medical home model
- Allow wider variety of providers (nurses or others) to operate in rural geographic areas and treat underserved populations
- Improve management of chronic conditions

Staff:

Admin: House- Jenn Holcomb

Lead: House- Randy Chun/John Walz

Back Up: Senate- David Godfrey/Mary Nienow

COST CONTAINMENT: RESTRUCTURE THE HEALTH CARE SYSTEM THROUGH THE IDENTIFIED SAVINGS

Members:

Senator Linda Berglin, co-chair

Rep. Paul Thissen, co-chair

Senator Julie Rosen

Rep. Jim Abeler

Rep. Tom Huntley

Tara Garman Erickson

Marnie Moore-Lindman, Larkin Hoffman Daly & Lindgren Ltd.

Jonathan Watson

Pete Benner, AFSCME

Donna Zimmerman, HealthPartners

Don Jacobs, Hennepin Faculty Associates

Charlie Fazio, Medica

Holly Rodin, SEIU

Larry Kryzaniak, HCMC

Yiscah Bracah, Center for Urban Health

Lezlie Taylor, Greater Twin Cities United Way

Nancy Nelson, Blue Cross Blue Shield of Minnesota

Mary Edwards, Fairview Health Services

Maureen O'Connell, Legal Aid

Scope:

- Translate all identified savings in the health care system into lower premiums and lower public program costs
- Create a methodology for defining minimally medically necessary benefits and maximum benefits
- Define "affordable"
- Explore distinctions between the underinsured and uninsured populations and determine numbers in each group

Staff:

Admin: Senate- Shannon Anderson/Shelley Polansky

Lead: Senate- Katie Cavanor/David Godfrey

Back Up: House- Jen McNertney/John Walz

DEVELOPMENT OF NEW COST CONTAINMENT STRATEGIES

Members:

Senator Ann Lynch, co-chair

Rep. Jim Abeler, co-chair

Senator Michelle Fischbach

Rep. Sandy Peterson

Rep. Matt Dean

Barbara Burandt, Minnesota HomeCare Association

Holly Rodin, SEIU

Carolyn Pare, Buyers Health Care Action Group

Sue Stout, Minnesota Hospital Association

Erin Sexton, MN Chamber

Bobbi Daniels, University of Minnesota Physicians

Jonathan Ravdin, U of M Medical Center/Fairview

Marc Swiontkowski, Chair of Orthopedics, U of M

Patricia Coldwell, Association of Minnesota Counties

Mary Jo George, MN Nurses

Dr. Barry Bershow, Fairview Clinics

Corrine Ertz, American Cancer Society - Midwest Division

Mike Lenz, Medica

Todd Johnson, Allina

Scope:

- Discuss new strategies to achieve cost containment within the health care system that would go beyond those in group 'A'

Staff:

Admin: Senate- Shannon Anderson/Stacy Ellefson

Lead: Senate- Katie Cavanor

Back Up: House- Dan Pollock

PUBLIC HEALTH

Members:

Senator Patricia Torres Ray, co-chair

Rep. Steve Gottwalt, co-chair

Senator John Marty

Senator Kathy Sheran

Rep. Mary Ellen Otremba

Rep. Kim Norton

Rep. Kathy Tingelstad

Bruce Cantor, Pediatric Obesity Work Group

Marc Manley, Blue Cross and Blue Shield of Minnesota

Carolyn Suerth Hudson, Midwest Dairy Council

Ellie Ulrich Zuehlke, Allina

Pat Arndt, Planning, MN-DNR Division of Parks & Recreation

Cindy Hiltz, School Nurse- Anoka

Dr. Sarah Jane Schwarzenberg, Pediatric Weight Management Clinic

Maureen Cassidy, American Heart Association

Kevin Morris, Coca Cola

Mavis Brehm, Westside Community Health Center

Guilford Hartley, Director of the Obesity Program at HCMC

Carol Berg, UCare Minnesota

Jennifer Monroe, Fremont Community Health Services, Inc.

Jodie Rohe, Central MN Childhood Obesity Prevention Initiative

Patty Bowler, Minneapolis Department of Health and Family Support

Scope:

- Evaluate other states' and organizations' proposals to address childhood obesity
- Promote early detection and prevention of chronic conditions
- Assure access to and improve the quality of health services in the area of prevention

Staff:

Admin: House- Jenn Holcomb
Lead: House- Emily Cleveland
Back Up: Senate- Joan White

INSURANCE MARKET REFORM

Members:

Senator Mary Olson, co-chair

Rep. Diane Loeffler, co-chair

Senator Linda Scheid

Senator Dan Skogen

Senator David Hann

Rep. Sondra Erickson

Rep. Kathy Brynaert

Peter Benner, AFSCME

Dr. Richard Geier, MMA President

Dan Schmidt, small business owner

Mike Harristhal, HCMC

Kathy Mock, Blue Cross Blue Shield of Minnesota

Rich Sykora, Medica

Dave Dziuk, HealthPartners

Tim Adams, The Minnesota Association for Justice

Mary Jo George, MN Nurses

Holly Rodin, SEIU

Anne Morse, AFSCME Council 65

Scope:

- Evaluate reforms that allow the insurance market to be more competitive
- Ensure that products offer real coverage and are obtained in a cost efficient manner
- Evaluate the issue of guarantee issue
- Address the inequality of employers as the basis of coverage
- Look at changes made to ERISA law since 1992
- Look at what would need to change if coverage is mandated

Staff:

Admin: House- Jenn Holcomb

Lead: House- Tom Pender

Back Up: Senate- Chris Stang/Darlene Sliwa

HEALTH CARE FOR LONG-TERM CARE WORKERS

Members:

Senator Paul Koering, co-chair

Rep. Patti Fritz, co-chair

Senator Linda Berglin

Rep. David Bly

Barbara Burandt, Minnesota HomeCare Association

Connie Menne, REM MN, Inc.

Kathy Fodness, SEIU

Sally Erickson, D.A.C., Inc

Jane Peltier, Merrick, Inc.

Bruce Nelson, Association of Residential Resources in Minnesota

Lori Meyer, Minnesota Health and Housing Alliance

Todd Bergstrom, Care Providers of Minnesota

Bill Spartz, Nursing home representative for UFCW LOCAL 653

Heidi Holste, AARP

Tom Burke, AFSCME

Scope:

- Utilize medical assistance funds to provide health insurance for long-term care workers

Staff:

Admin: Senate- Shannon Anderson/Shelley Polansky
Lead: Senate- Dave Giel
Back Up: House- Randy Chun

SINGLE PAYER HEALTH CARE

Members:

Rep. Ken Tschumper, co-chair

Senator Sharon Erickson Ropes, co-chair

Senator Yvonne Prettner Solon

Senator John Doll

Senator Mary Olson

Senator Ray Vandeveer

Rep. Tina Liebling

Rep Carolyn Laine

Rep. Matt Dean

Eileen Weber

Barb Hollenbeck

John M. Schwarz, United Health System

Dr. Robert W. Geist, retired physician

Dr. Jim Hart, MUHCC

Scope:

- Create a methodology for defining minimally medically necessary benefits and maximum benefits
- Develop a plan of transition for current public and private programs
- Identify the cost to implement a single-payer system
- Explore financing opportunities

Staff:

Admin: House- Jenn Holcomb

Lead: House- Dan Pollock/ John Walz

Back Up: Senate- Katie Cavanor/David Godfrey

BRIDGING THE HEALTH CONTINUUM

Members:

Senator Kathy Sheran, co-chair

Jan Malcolm, Courage Center, co-chair

Rep. Larry Hosch

Rep. Paul Thissen

Michelle Fedderly, Hospice Minnesota

Todd Monson, Hennepin County

Joan Willshire, MN Council on Disability

Dale Thompson, Benedictine Health System

Glen Andis, Medica

Cathy Barr, MN Homecare Association

Patricia Coldwell, Association of Minnesota Counties

Paul Johnson, Hennepin Faculty Associates

Mary Kennedy, EverCare

Gayle Kvenvold, MN Health and Housing Alliance

Mike Weber, Volunteers of America

Ghita Worcester, UCare Minnesota

Sue Abderholden, NAMI Minnesota

Scope:

- Compare the reform strategies that have been developed or are being developed for acute and episodic care, long-term care, mental health care, health care for the elderly, and health care for people with physical or developmental disabilities
- Identify potential conflicts and barriers between the different reform proposals and the opportunities to improve coordination and integration
- Provide information and recommendations to the Legislative Commission, the Governor's Transformation Task Force, and to other agencies, working groups and coalitions working on health care reform on how to coordinate or integrate reform strategies across all health care sectors

Staff:

Admin: Senate- Shannon Anderson/Shelley Polansky

Lead: Senate- Dave Giel

Back Up: House

Appendix 2: Legislative Implementation Timeline

Legislative Implementation Timeline

Public Health		
Action	*Who*	*When*
(1) Fund the Comprehensive Health Promotion Plan (Annually at $41.5M).	Legislature	July 1, 2008
Implement the Comprehensive Health Promotion Plan.	MDH	July 1, 2008
Establish a confidential online health-risk assessment tool for all citizens to use.	MDH	January 1, 2009
Recommend to the legislature, ways to ensure that schools are held accountable for making progress on health promotion goals, particularly health goals that are closely related to learning.	MDE and MDH	June 30, 2009
Report to the legislature on progress of the Comprehensive Health Promotion Plan and update the plan (annually).	MDH	July 1, 2009
(2) Adopt statewide curriculum standards for health, nutrition, and physical education.	Legislature	July 1, 2008
Provide funding for schools to implement the statewide curriculum standards for health, nutrition, and physical education.	Legislature	July 1, 2010
Enforce the statewide curriculum standards for health, nutrition, and physical education	MDE	Starting in 2010-2011 school year
(3) Begin tracking childhood obesity rates in Minnesota using BMI data.	MDH	July 1, 2008
Report to the public results of monitoring rates of childhood obesity in Minnesota (annually).	MDH	July 1, 2009
Health Care Homes and Provider Education		
(1) Establish health care homes for all state program enrollees.		
Establish care coordination advisory committee.	DHS/MDH	July 1, 2008
Establish health care home standards, criteria for comprehensive care plans, care coordination fee, and health care home evaluation criteria.	DHS/MDH	January 1, 2009
Establish health care home standards for managed care, criteria for data collection, withholds, and recapturing methodology.	DHS/MDH	January 1, 2009
Begin certifying clinicians as health care homes.	DHS/MDH	July 1, 2009
Establish health care home collaboratives.	DHS/MDH	July 1, 2009
Implement health care home model for state managed care programs.	Health plans	July 1, 2009

Health Care Homes and Provider Education		
Action	*Who*	*When*
Annual reports on health care home administration under fee-for-service.	DHS	December 15, 2009 and each December 15 thereafter
Annual reports on managed care rates and health care savings, related to health care home model implementation.	DHS	December 15, 2009 and each December
(2) Require state health care program enrollees to select a primary care provider and complete a health assessment; education and outreach.		
Education and outreach related to health care homes and primary care.	DHS	January 1, 2009
State program enrollees to choose primary care clinics and complete health assessments.	DHS/program enrollees	January 1, 2009
DHS to encourage enrollees, as appropriate, to choose a health care home.	DHS/program enrollees	July 1, 2009
(3) Contingent payments to managed care plans.		
Payment of assessment fee for enrollees with complex or chronic conditions.	DHS	July 1, 2009
Capitation payments paid only after enrollee chooses a health care home.	DHS	July 1, 2009
(4) Expand funding for primary care and rural physician training, APRN training, and to address faculty shortages for primary care medicine and nursing.	MDH	July 1, 2008 (subject to available appropriation)
(5) Study of pharmacist integration with primary care.	MDH	January 15, 2009
(6) Recommend scope of practice and licensure changes to legislature.	MDH/DHS	Ongoing, as needed
Affordability		
(1) Employers with 3 or more employees to establish Section 125 plans.	Employers	January 1, 2009
(2) Establish Health Insurance Exchange.	MDH	October 1, 2008
(3) Provide premium subsidies to persons up to 400 percent FPG, for policies meeting standards established by Exchange.	MDH/DHS	July 1, 2009
(4) Raise MnCare income limit and establish new MnCare sliding scale.	DHS	January 1, 2009
(5) Increase or eliminate MnCare inpatient hospital annual limit.	DHS	January 1, 2009

Continuity of Care		
Action	*Who*	*When*
(1) Eliminate MnCare four-month uninsured requirement.	DHS	January 1, 2010
(2) Delayed verification for state health care programs.	DHS	January 1, 2010
(3) MnCare first month premium exemption.	DHS	January 1, 2010
(4) Grace month for state health care program enrollees.	DHS	January 1, 2010
(5) Improve automation and coordination for state health care program outreach and enrollment.	DHS	Ongoing
(6) Reduce asset documentation requirements for MA.	DHS	January 1, 2009
(7) Provide state health care program renewal forms in the appropriate foreign language using an automated process.	DHS/county agencies	July 1, 2008
(8) Update enrollee addresses at each contact.	DHS/county agencies	July 1, 2008
Health Insurance Reform		
(1) Data uniformity—performance measures.	MDH	2008 interim
(2) Community benefits recapturing—health plans.	MDH	January 1, 2009
(3) Expand small employer definition.	MDH & MDC	January 1, 2009
(4) Modified community rating.	MDH & MDC	January 1, 2009
(5) Merge individual and small employer markets.	MDH & MDC	July 1, 2009
(6) Consider changed MCHA funding source.	HCAC	2008 interim
Cost Recapturing Mechanisms		
(1) Increase MA reimbursement rate to primary care physicians who agree to practice in designated areas.	DHS	July 1, 2008
(2) Establish a savings recapture assessment.	Legislature	1st quarterly assessment due January 1, 2010
(3) Increase the tobacco impact fee by 25 cents.	Legislature	July 1, 2008
Establish a new fund.	Legislature	July 1, 2008
Dedicate revenue for public health initiatives.		July 1, 2008

Cost Recapturing Mechanisms		
Action	*Who*	*When*
(4) Establish community benefit standards for health plan companies. – Recommendations to legislature by January 15, 1009.	MDH	January 15, 2009
(5) Create a budget forecast mechanism to recognize savings from health care initiatives and recapture savings.	Dept. of Finance & DHS	January 15, 2009
New Cost Containment Initiatives		
(1) Establish an independent board to develop an evidence-based benefit set. – this benefit set will be the benchmark of the plans offered through the health exchange	MDH & DHS	January 1, 2009
(2) Establish an evaluation process for procedures, medications, and new technologies.	MDH & DHS	January 1, 2009
(3) Incorporate the use of patient directed decision-making process within the state health care programs.	DHS	January 1, 2009
(4) Develop a midlevel dental practitioner to work within a collaborative agreement with a licensed dentist.		July 1, 2008
(5) Explore the feasibility of a community paramedic pilot project and present recommendations to the legislature.	MDH	January 15, 2009
Long-Term Care Workers		
(1) Obtain data needed to determine the cost of a future rate increase to long-term care employers and report back to legislature with a cost estimate and recommendations.	DHS	December 1, 2008
(2) Implement program.		July 1, 2009

Appendix 3: Fiscal Implementation Timeline

Fiscal Implementation Timeline

I. HCAC Estimated Savings

	FY 2011		FY 2015	
	$ millions	% of total spending	$ millions	% of total spending
Base: Projected Spending	$41,100		$57,400	
Potential Cost Savings:				
Cost Containment Reforms	1,644.0	4.0%	2,296.0	4.0%
Prevention and Health Promotion:				
Overweight and Obesity	164.4	0.4	1,262.8	2.2
Smoking	493.2	1.2	1,664.6	2.9
Alcohol and Drugs	82.2	0.2	401.8	0.7
Cost of Public Health Interventions	(57.1)	-0.1	(57.1)	-0.1
Subtotal Prevention	682.7	1.7	3,272.1	5.7
Total Cost Savings	**2,326.7**	**5.7**	**5,568.1**	**9.7**
Health Care Savings Recapture Assessment - 40% of Savings	**$930.7**	**2.3%**	**$2,227.2**	**3.9%**

II. Impact of Reforms on Health Insurance Rate

	2007	2008	2009	2010	2011	2012	2013	2014
Minnesota State Population Estimates[1]	5,197,621	5,246,479	5,295,796	5,345,576	5,395,824	5,446,545	5,497,743	5,549,421
Minnesota's Baseline Uninsurance Rate	7.4%							
Baseline of Number of Uninsured Minnesotans	384,624	388,239	391,889	395,573	399,291	403,044	406,833	410,657
Reforms to Reduce Uninsured	**FY 08**	**FY 09**	**FY 10**	**FY 11**	**FY 12**	**FY 13**	**FY 14**	**FY 15**
2007 Session Changes	4,981	25,629	46,200	53,826	53,826	53,826	53,826	53,826
2007 Dependent Coverage Change	25,516	51,032	51,032	51,032	51,032	51,032	51,032	51,032
Expand MinnesotaCare Eligibility to 300% of FPG - 6% Premiums	0	551	4,949	7,840	7,840	7,840	7,840	7,840
Eliminate Four-month without Insurance Requirement for MNCare	0	0	7,700	15,400	15,400	15,400	15,400	15,400
Establish Insurance Exchange with Section 125 Plans	0	9,000	9,000	9,000	9,000	9,000	9,000	9,000
Total New Enrollees	**30,497**	**86,212**	**118,881**	**137,098**	**137,098**	**137,098**	**137,098**	**137,098**
Number of Uninsured	354,127	302,027	273,008	258,475	262,193	265,946	269,735	273,559
Percent of Population Uninsured	6.8%	5.8%	5.2%	4.8%	4.9%	4.9%	4.9%	4.9%
Percent of Population Insured	**93.2%**	**94.2%**	**94.8%**	**95.2%**	**95.1%**	**95.1%**	**95.1%**	**95.1%**

III. Costs of HCAC Reforms – *(dollars in thousands)*

	FY 08	FY 09	FY 10	FY 11	FY 12	FY 13	FY 14	FY 15
Expand MinnesotaCare Eligibility to 300% of FPG - 6% Premiums	$0	$4,417	$19,413	$28,180	$32,407	$32,407	$32,407	$32,407
Eliminate Four-month without Insurance Requirement for MNCare	0	0	17,774	29,209	33,590	33,590	33,590	33,590
Establish Insurance Exchange-MDH	0	8,905	3,150	0	0	0	0	0
Section 125 Revenue Loss -Tax Committee	0	2,300	6,300	8,100	8,100	8,100	8,100	8,100
Increase MinnesotaCare Hospital Caps to $20,000	0	3,236	9,766	11,213	12,895	12,895	12,895	12,895
Total Cost	**$0**	**$18,858**	**$56,403**	**$76,702**	**$86,992**	**$86,992**	**$86,992**	**$86,992**

IV. Implementation

July 2008 - Health Impact Fee increased, public health interventions and cost containment efforts begin
October 2008 - Health Care Exchange established
January 2009 - Section 125 plans; MinnesotaCare eligibility expansion and new premium schedule implemented; MinnesotaCare hospital cap increased
July 2009 - Health Care Savings Recapture Assessment goes into effect
January 2010 - MinnesotaCare four-month barrier eliminated; Rolling eligibility and delay verification implemented

V. Items for Which Fiscal Notes Have Been Requested, but not Received

Rolling eligibility
Delayed verification
Waive first month of MinnesotaCare premium
Renewal forms in foreign languages
Conduct study and hire actuary for LTC employee insurance
Subsidies for individuals between 300% and 400% FPG

[1] Population estimates are extrapolated from the US Census Bureau's 2007 population estimate using growth rates found in *Interim State Population Projections*, April 21, 2005.

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